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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 1 JANUARY 12, 1979

Register now . . .

or the 1979 Michigan Con-
erence on Maternal and
erinatal Health Feb. 28-
arch 1 at the Hyatt
egency Dearborn. A reg-
istration form and pro-
gram details are on page 2
f this issue of Medigram.

MS COMPLYING
TH FTC SUBPOENA

MS has placed a large volume
materials in the hands of
e Federal Trade Commission
compliance with the FTC
bpoena against MSMS dated
v. 1. Some of the material
s hand-delivered to the FTC
shington office by MSMS
gal counsel. MSMS is work-
g hard to comply with the
bpoena, though information
d to be gathered during the
lidays, and though the
rust of the subpoena is not
ear to MSMS leaders and
aff.

RBERT A. AUER
ADS MICHIGAN HEALTH COUNCIL

rbert A. Auer, former MSMS
puty director and head of
e MSMS Department of Commun-
ations, Public Service and
ysician Education, is the
w executive vice president,
chigan Health Council. Mr.
er began his new duties
n. 2 after service with MSMS
r 19 years. He fills a
cancy created with the death
the former MHC director,
hn A. Doherty. Mr. Auer
rmerly held executive posi-
ons with the Muskegon Chron-
le and the Michigan State
iversity continuing educa-
on service. The Health
uncil conducts health man-
wer surveys, provides
alth education for the pub-
c, recruits physicians and
ntists for the state and
ovides health career coun-
ling.

Medicaid programs to be affected by shortfall in state revenues

MSMS has been alerted that an anticipated $160 million shortfall in state revenues will have an adverse impact on the Medicaid program and reimbursements for Medicaid providers, particularly physicians, hospitals and pharmacists. David Siegel, MD, attended a Jan. 8 meeting called by the Michigan Department of Social Services (MDSS) and learned of the administrative plan to contain costs by limiting Medicaid expenditures due to a loss of $45 million in state funds to MDSS. While aspects of the plan will affect physicians, fee increases for the 100 most frequently performed procedures, which represent 80 percent of total physician billings, will still be increased to the levels projected in the 1978-79 appropriations act. The proposal affecting physician reimbursements will be discussed by the MSMS Medicaid Liaison Committee Jan. 16 with a recommendation anticipated for The Council Jan. 24.

MSMS Council to hear report of physicians', Blues' activities

Activities of physician and Blue Cross/Blue Shield of Michigan work groups during the past six months will be reported to the MSMS Council during a morning meeting Jan. 24 preceding The Council's regular afternoon meeting. The physician work group--Donald R. Crandall, MD, Muskegon; Frank B. Walker II, MD, Detroit; and John B. Bryan, MD, Royal Oak--will report. The Council desires full information and adequate discussion time before the MSMS House of Delegates meets in May. Following the January Council meeting, the work groups will publicize their activities and proposals to all Michigan physicians. Look for further details in Michigan Medicine and Medigram.

Each MSMS member . . .

is asked to complete and return the brief questionnaire on page 3 of this issue of Medigram. The questionnaire will help MSMS form future policies and plan legislative activities regarding professional liability insurance in Michigan.

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MAR 21 1980

18th Annual Michigan Conference On Maternal And Perinatal Health

(Sponsored by MSMS and nine other organizations)

An outstanding national authority will open the Wednesday morning and afternoon sessions with a comprehensive presentation on the subject matter to be covered. Following his presentation, three different case histories relating to the subject will be presented by three different panelists. The case histories will then be discussed by the presenter, other panelists, and the featured main speaker, with input from the audience invited.

Wednesday, February 28

(Maximum of 6 hours Category I Credit)

8:30 a.m. "Patient Profiles — The Mother"

Presiding: Bruce A. Work, Jr., MD, Ann Arbor, Co-chairman of Conference Planning Committee.

Featured Speaker: Irwin R. Merkatz, MD, Professor of Reproductive Biology, University Hospitals of Cleveland, Cleveland, "Obstetrical High Risk Patient"

Case History Panelists: Clinton H. Dowd, MD, Flint; Miriam F. Daly, MD, Albion; Gloria Forgash, RN, Saginaw.

1:30 p.m. "Patient Profiles — The Baby"

Presiding: John W. Hallitt, MD, Flint, Co-chairman of Conference Planning Committee.

Featured Speaker: L. Joseph Butterfield, MD, Director of Perinatology, Children's Hospital, Newborn Center, Denver, "Pediatric High Risk Identification and Stabilization."

Case History Panelists: James D. Johnston, MD, Traverse City; Donald DeWitt, MD, Kalamazoo; Rochelle M. Igrisan, RN, Petoskey.

Thursday, March 1

(Maximum of 5 hours Category I Credit)

8:30 a.m. "After the ICU — After the Nursery"

Presiding: Mary A. Scoblic, RN, MDPH, Lansing.

Featured Speakers: William J. R. Daily, MD, and Lester E. Mayes, MD, Co-Directors, Arizona State Newborn Transport and Intensive Care Program, Phoenix, "Development of Regional Intensive Care Center in Arizona;" Jess G. Thoene, MD, Assistant Professor of Pediatrics, University of Michigan Medical School, and Coordinator, Genetic Screening Program, Michigan Department of Mental Health, Ann Arbor, "Genetic Screening for Mental Retardation;" Pamela M. Fitzhardinge, MD, Director, Neonatal Followup Program, Hospital for Sick Children, Toronto, "Bonding — Followup on Infant's Discharge from Neonatal ICU;" Irwin R. Merkatz, MD, Professor of Reproductive Biology, University Hospitals of Cleveland, "Importance of Maintaining Lines of Communication Open to the Mother."

1:30 p.m. "Changing Concepts"

Presiding: Lee B. Stevenson, MD, Farmington Hills, Chairman of MSMS Committee on Maternal and Perinatal Health.

Featured Speakers: Warren H. Pearse, MD, Executive Director, American College of Obstetricians and Gynecologists, Chicago, "Facts and Fantasies of Home Delivery;" an HEW representative, and a national science news writer will be invited to speak.

Hyatt Regency Dearborn

ADVANCE REGISTRATION

Please complete and mail to the MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH, P.O. Box 950, East Lansing, MI 48823.

Name ____________________
Address ____________________
City ____________________ **Zip** __________

Please check one:

Physician	RN	LPN	Student
☐	☐	☐	☐

Registration Fee: Physicians, $15.00 per day
Nurses, $8.00 per day

Medical/Nursing Students, No charge
Medical House Officers, No charge

		Physician	Nurse	Student/House Officer
Please Check:	**Wednesday Sessions**	☐ **$15.00**	☐ **$8.00**	☐ **No Charge**
	Thursday Sessions	☐ **$15.00**	☐ **$8.00**	☐ **No Charge**
	TOTAL	**$** ______	**$** ______	**$** (none)

Make checks payable to Michigan State Medical Society

nportant! Please read and complete this form provide professional liability data to MSMS

MS is gathering data regarding the
rrent professional liability insur-
ce situation in Michigan. The in-
rmation received from the survey
low will assist MSMS in formulating
ture policies and in planning legis-
tive activities regarding availabil-
y of insurance in Michigan.

ree years ago MSMS led the effort to
ss legislation to help relieve a
isis when physicians were unable to
t professional liability insurance.
e MSMS-initiated legislation also
lped to improve the reporting and
rt systems regarding malpractice in
chigan.

This legislation has had time to take effect and MSMS now needs information to determine how effective the new laws have been and whether there is need for further action.

Your assistance in filling out the enclosed survey will be greatly appreciated. The questions are designed to help MSMS measure physicians' relative satisfaction with the present companies and the potential market for additional coverage. This data also will be useful in determining how much the private market has improved since 1974.

Thank you for your cooperation.

lease complete form below and return to John Richards, MSMS, Box 950, East Lansing, 48823)

PROFESSIONAL LIABILITY QUESTIONNAIRE

Are you satisfied with the present mal-
actice coverage in Michigan?

Yes ____ No ____ No Opinion ____

What improvements do you feel are needed
the coverage presently available?
lease check)

- a. Claims made - type policy ______
- b. Periodic premium payments ______
- c. Increased maximum coverage from $200,000/$600,000 ______
- d. Umbrella coverage ______
- e. Lower coverage (e.g. $25,000/$75,000) ______
- f. Other (please specify) ______________

3. Have you received satisfactory service from your present carrier?

Yes ____ No ____ No Opinion ____

4. Which insurance company are you presently covered by? (Please check)

- a. Brown-McNeely ______
- b. Medical Protective ______
- c. Michigan Physicians Mutual Liability ______
- d. Other (please specify) ______________

5. What is your present insurance classification? ______________

6. What is your specialty? ______________

IMPROVE YOUR TECHNIQUES FOR NEWS INTERVIEWS AT FEB. 1 MSMS WORKSHOP

Lessons on being interviewed by the news media will be passed along to specialty and component society members who attend the Feb. 1 workshop planned at MSMS headquarters. The news director of Detroit radio station WJR will be among the professionals on hand to help physicians learn to organize their thinking as they face an interview, how and when to respond to the media and to provide tips on delivery and appearance. Lists of news media contacts will be included in a kit of materials to be distributed. Please contact Mert Scholten at MSMS headquarters to register. The nominal fee of $15 includes luncheon and materials.

DOCTOR RAY ELECTED

Kenneth J. Ray, MD, Trenton family physician, is new president-elect of the Wayne County Medical Society. Doctor Ray's election officially was announced at the WCMS annual meeting Jan. 8 when C. Jackson France, MD, was installed as 1979 president. Doctor France succeeds Carl A. Gagliardi, MD.

Stringent regulations for sterilizations under Medicaid in effect Feb. 6

The federal government (HEW) has ignored strong objections made during the past year by the Michigan Department of Social Services, MSMS, and the American College of Obstetricians/Gynecologists and mandated stringent new regulations for sterilizations under Medicaid. Physicians will soon receive complete information from MDSS, but should be aware of the significant changes which become effective Feb. 6, 1979:

1) The current 72-hour waiting period will be changed to not less than 30 days nor more than 180 days.
2) A new federal consent form is mandatory, and will replace the existing MDSS form. After the initial notification by MDSS, physicians may reorder supplies of the new mandated form.
3) Hysterectomies for family planning purposes will not be covered.
4) Shortly before sterilization, the physician must orally present the informed consent information and advice to the recipient.
5) The physician must sign the informed consent form certifying that all federal requirements have been met subsequent to the sterilization.
6) Sterilizations are not allowed for persons under 21, the mentally incompetent, or the institutionalized.

MDSS has assured MSMS that Hot Line personnel will be prepared to answer physicians' questions. Call (800) 292-2550.

Preliminary State Health Plan ready for SHCC's approval

The full Preliminary State Health Plan will be considered for final approval at the Jan. 18 meeting of the Statewide Health Coordinating Committee. The MSMS Steering Group on Health Planning will meet the same day to discuss MSMS strategies for legislative consideration of the State Health Plan expected in February or March. The SHCC has made considerable revisions in the 750-page preliminary plan developed by the Office of Health and Medical Affairs, including several changes supported by MSMS.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Managing Editor: Judith Marr

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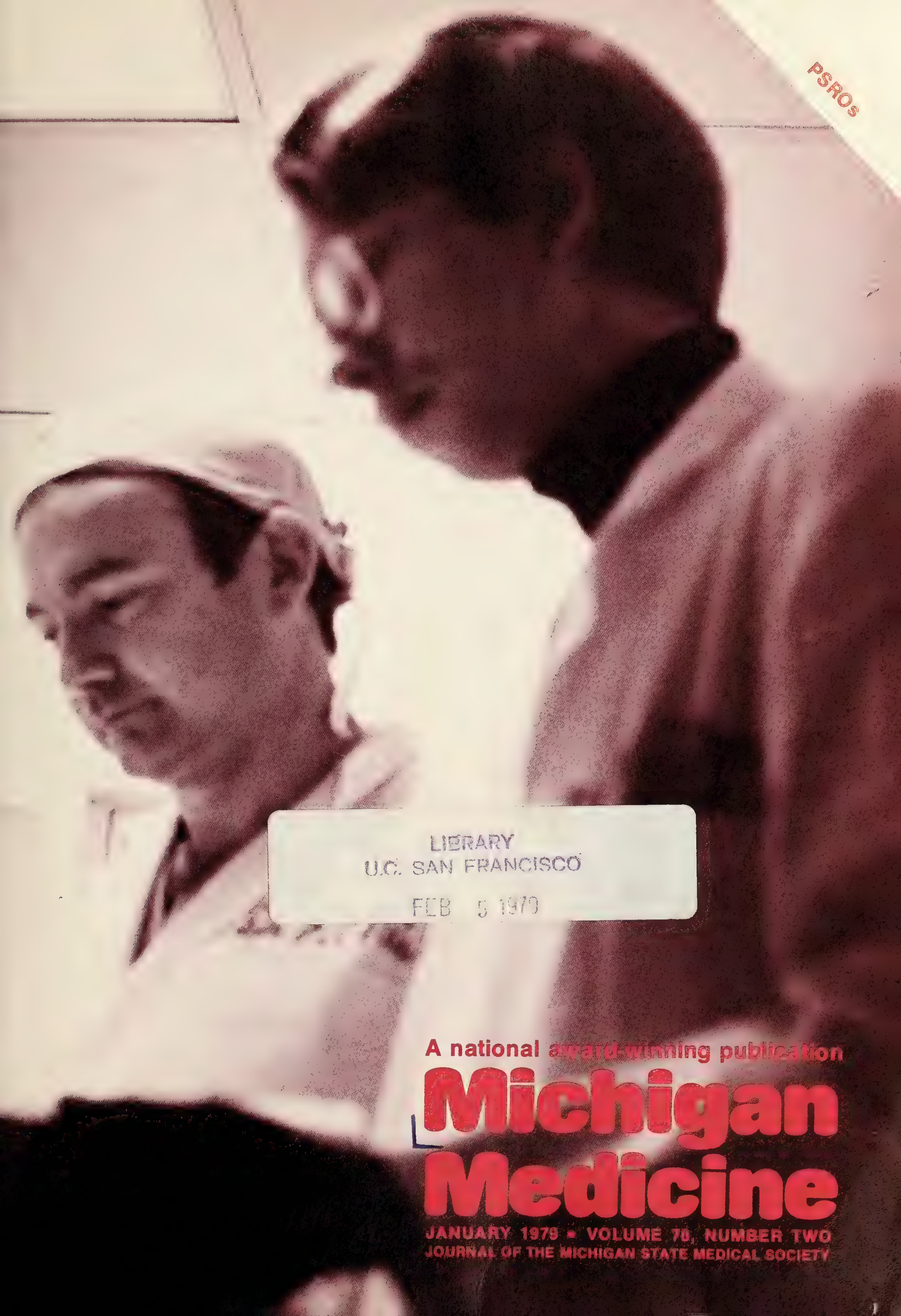

PSROs

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Michigan Medicine

JANUARY 1979 • VOLUME 78, NUMBER TWO
JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

IMPROVE YOUR
FOR NEWS IN
AT FEB. 1

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Contents

A … award-winning publication
Michigan
Medicine

Reviewing medical charts at Lansing's E. W. Sparrow Hospital are, Fredrick O'Neill, MD, left, committee member, and William Anderson, MD, chairman, utilization review committee. Their activity is typical of the work being concentrated across the state in the new Professional Standards Review Organizations. (See facing page)

Special Section

1 This issue of *Michigan Medicine* brings you up to date on the status of Michigan's 10 PSROs.

Features

7 How MSMS is serving the public, with some good ideas for component society projects; Mert Scholten

11 The 1978 Annual Scientific Meeting: How MSMS presented 25 half-day courses for 1,305 physicians — on just one of the three big days at the Detroit Plaza

14 Send a letter to MSMS, Doctor, with your ideas for the 1979 Annual Scientific Meeting

16 Photo spread on the 1978 Annual Scientific Meeting

18 Report on the medical costs containment seminar during 1978 MSMS Annual Scientific Meeting; Susan Perkin

22 'Superstars' to lead 1979 Maternal and Perinatal Health Conference Feb. 28-March 1; Willah Weddon

25 Latest MSMS closed claims survey data; John A. Richards

34 House majority floor leader profiled; Willah Weddon

44 Michigan Medical Treatment Decision bill; Maryanne Butt

46 Certified eye enucleators; Betty L. Herring

54 Eulogy for the late Tony Doherty; Brooker L. Masters, MD

Departments

24 Meetings

31 Welcome; Ad index

36 MPMLC clipsheet

43 Category I courses

48 News

53 Letters

56 Deaths

58 Classified ads

60 President's page

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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MSMS works with PSROs to create best possible peer review system

MSMS work with PSROs goes back to 1972, when federal legislation (PL 92-603) first called for the creation of the physician quality-review units.

At the time, the MSMS House of Delegates resolved MSMS policy should coincide with the AMA's to "continue efforts for repeal of PL 92-603 while simultaneously exerting leadership with constructive suggestions for amendments coupled with aggressive efforts to develop appropriate rules and regulations."

When it became obvious the legislation could not be repealed, MSMS worked to help physicians create the best possible peer review system, according to the government requirements.

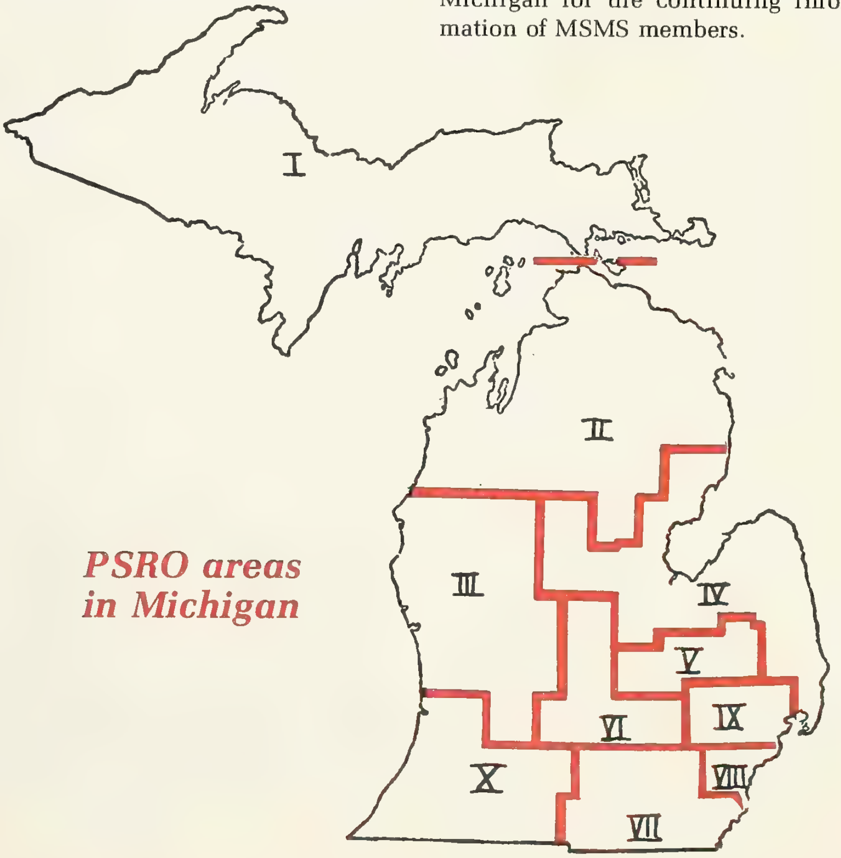
In 1974, MSMS established the Michigan PSRO Support Center with a grant from HEW. Through the Center, MSMS provided technical assistance to interested county medical societies and other physician groups to establish PSROs. MSMS has since followed with interest the growth and development of all 10 physician-run Michigan PSROs. MSMS currently is continuing liaison with PSROs on such matters as dealing with HEW and cost effectiveness of PSRO reviews consistent with quality health care.

Recently MSMS nominated Daniel J. Fall, MD, Ann Arbor, for appointment by HEW on the soon-to-be-formed statewide professional standards review council.

The AMA's involvement with PSROs continues to grow, also. The AMA House of Delegates at its December interim meeting in Chicago approved the PSRO status report of the AMA Council on Medical Service. The report stated the Council's Ad Hoc Committee on PSROs "will continue to closely monitor the PSRO program during this period of crucial program evaluation and change." The report also stated "the Council and its Committee remain convinced that strong support should be expressed for continuation of the PSRO program as a professionally directed effort to ensure the quality and appropriateness of care provided to patients."

Most Michigan PSROs report a high rate of physician participation. The importance of the PSROs as physician review organizations has continued to grow.

Michigan Medicine presents the following reports of PSRO progress in Michigan for the continuing information of MSMS members.



PSRO areas in Michigan

MAOPS view

DOs, as well as MDs, are eligible to serve on PSROs. The following resolution of the American Osteopathic Association describes the current position on PSROs of the AOA and Michigan Association of Osteopathic Physicians and Surgeons. It was passed in July, 1978.

WHEREAS, the PSRO provision of Public Law 92-603 is now almost fully implemented, and

WHEREAS, the osteopathic profession has generally been accorded equitable treatment and full participation in the PSRO program, at all levels, and

WHEREAS, osteopathic physicians have a vital interest in providing continued quality health-care delivery, and

WHEREAS, the PSRO program still represents a preferable alternative to third-party review; therefore, be it

RESOLVED, that the American Osteopathic Association urge its members to continue to be active in the development and operation of all Professional Standards Review Organizations to insure true peer review.

360969

Area I

Henry J. Barsch, MD
Marquette

The Upper Peninsula of Michigan is a distinctive and unique area in its geography, climate and population. It is a sparsely populated area encompassing 16,500 square miles but only 300,000 residents. Winters are long and snowfalls heavy. Such factors present problems for a regional review system.

Because UP physicians wanted to have their own review program instead of an outside one, the Upper Peninsula Quality Assurance Association (UPQAA) was founded as a physician organization in 1974 and has been operational as a conditional PSRO since July of 1975. Seventy-one percent of UP physicians are UPQAA members.

In addition to acute care review, UP physicians have also supported a Long Term Care project which we feel is a model for rural areas of the nation.

UPQAA has been cost-effective and some quality gains have been realized. As physicians we strive for further quality care gains, realizing we must also see that the public gets what it pays for if we are to fulfill PSRO requirements. We recognize two key areas of concern:

1. Trying to keep our physician colleagues informed so as to overcome hostility to any government program. I am personally convinced that the federal government has given us four years and funding to let us develop physician organizations and if we don't grab the ball, hold it and carry it, we will have ourselves to blame if we are left out in the cold.

2. Loss of confidentiality would essentially ruin a functional physician organization. We have *not* lost it and don't intend to.

We feel the PSRO program is distasteful at times but is workable and is a lot better than what might have happened to us and our patients.

Area II

James Greenwood, MD
Alpena

The Michigan Area II PSRO was incorporated in January 1978. It received a 12-month planning contract in May and established a Traverse City administrative office in June. By October, the PSRO leaders had met individually with representatives from the 20 hospitals in the 21-county, 140-by-150-mile area. We began, in November, enrolling members from the 520-member physician community. The response to the enrollment effort has been immediate and heavy.

The Area II acting Board of Directors includes nine physicians who are currently practicing throughout the area. The administrative staff numbers three.

Much of the current effort is directed toward the completion of an exhaustive hospital review plan, which will be implemented after mid-1979 when the area's 30,000 annual federal titled hospital admissions will come under PSRO review

The objective of Area II PSRO is to help assure that health care provided in the area's acute care facilities is of a maximum quality, in relation to appropriate utilization, according to professional standards. This will be achieved by the implementation of a focused concurrent review program, medical care evaluation studies and ancillary service review. This program will generate profiles which, after careful analysis, will determine patterns of care. The overall program, as well as these profiles, will be monitored to assure that the goal of maximum quality, as previously defined, is achieved.

Doctor Barsch

Doctor Greenwood

Area III

Perry W. Green, Jr., MD
Grand Rapids

The Western Michigan PSRO has been on conditional status since March 1978 and has the responsibility for conducting utilization review in 28 acute care hospitals in the 12 western counties of Area III. To date WMPSRO has implemented review in 19 of these facilities and will be 100 percent implemented by the end of February 1979.

WMPSRO has become a strong voice of, and for the physicians of our community.

Both physicians and staff have presented testimony, background data, and position papers to express the physician communities' concerns relative to quality care and cost containment before the local HSA and meetings of the state SHCC, with a measure of success.

In an attempt to ascertain the level of physician support of PSRO in Area III, WMPSRO's board has authorized a scientific poll of area physicians for 1979.

In September 1978, the board approved the expeditious implementation of a "focused review program" which exempts from concurrent review all Medicare/Medicaid cases in individual hospitals whose lengths of stay and/or charges are below the area averages by diagnosis. Diagnosis groups with charges or LOS significantly above the area average are "focused in" for intensive concurrent review. Certain of these diagnoses are singled out for retrospective review or medical audit. In Area III, WMPSRO will initially "focus out" over 50 percent of Federally funded cases. HEW has commended WMPSRO for "its immediate response to the important task of focusing review to meet the challenge of limited resource utilization."

WMPSRO's board is determined to make the local physician-controlled peer review system work. We see it as private medicine's last chance to direct its own destiny. We are unanimous in our hope that the physicians of Michigan and the nation feel as we do and that they do not pass up this opportunity.

Area IV

T. A. Egleston, MD
Saginaw

Area IV PSRO of Michigan formally incorporated in March, 1976. In July, 1978, Area IV progressed to conditional status and became one of the first six PSRO's in the nation to be awarded a grant.

The service area for Area IV includes the counties of Arenac, Bay, Clare, Huron, Iosco, Isabella, Midland, Saginaw, St. Clair, Sanilac, and Tuscola.

Physician involvement in PSRO can best be illustrated by the fact that 69 percent of the total physicians in Area IV are now members. At its annual meeting on Sept. 28, the first elected board of directors of Area IV was announced. Committee chairmen were appointed at the October meeting.

Late in November, the staff conducted site visits to several hospitals in preparation for the implementation of binding review. Hospital reviews were expected to begin on Jan. 8. It is hoped all 25 hospitals in our 11 counties will be implemented by the end of July.

Area V

Frederick F. VanDuyne, MD
Flint

Professional Review Organization-GLSC, organized as a PSRO in 1975, has binding authority for reviewing Medicare and Medicaid hospital stays in Genesee, Lapeer, and Shiawassee Counties. The 550 practicing physicians in these counties admit 36,000 Medicare and Medicaid patients to acute care hospitals annually.

Genesee Medical Corporation, which shares PRO-GLSC's staff, conducts similar review for Blue Cross/Blue Shield in the three-county area. Review is conducted primarily by PRO-GLSC's review coordinators doing actual chart review in seven of the nine area hospitals. The two remaining hospitals use their own staff to conduct review, with PRO-GLSC monitoring their effectiveness.

PRO-GLSC's current projects include:

PERFORMING less than 100 percent concurrent review in order to concentrate exclusively on identified problem areas. This "focus in/out" program is currently based on diagnoses and specialty care areas (e.g., CCU); later, it will also be linked to individual physician activity.

PREPARING for review of the quality of care received by Medicare and Medicaid beneficiaries in nursing facilities.

CONDUCTING area-wide Medical Care Evaluation studies on topics or problems common to area hospitals to assure optimum patient care.

ESTABLISHING a plan for ancillary services review (i.e., pharmacy, X-ray, etc.).

DEVELOPING, with our area hospitals, a mechanism for sanctioning physicians with aberrant practice patterns.

PRO-GLSC's efforts have contributed to shorter average hospital stays; fewer diagnostic admissions; improved quality of care; more effective discharge planning; and more timely consultation, X-ray, and laboratory services.

Our physicians believe PSRO review is improving health care delivery in our area. We intend, through various methods (including our IPA/HMO), to provide the incentives and education needed to change our health care system, rather than allowing it to be replaced by a system operated and controlled by the federal bureaucracy.

Area VI

Bernard H. Smookler, MD
Lansing

PSROs in Michigan are rapidly gaining momentum. In our own area we have seen a lot of activity and change over the past year. Let me give you some highlights:

Central Michigan Medical Care Review, Inc. left the planning phase and entered the conditional phase on July 1, 1978. As a conditional PSRO we are now permitted and prepared to actually begin conducting concurrent utilization review, medical care evaluation studies, and profile analysis. By that I mean we can certify the necessity of a patient's admission to a hospital, insure that they remain in the hospital for the appropriate amount of time and help see that they are discharged to the appropriate level of care.

For the time being we are only concerned with patients whose care is paid for by the federal government. Over time we may offer our review services to private insurance companies that have an interest in cost containment, quality assurance, and claims verification. We can do special studies (retrospective audits of care) within a hospital to identify aberrant patterns or to confirm the value of a new procedure or technique. We can also make comparisons between hospitals so that they can learn from each other.

That brings to mind another issue — physicians' sentiments about the PSRO program. I think there has been a real turnaround in this area.

A few years ago we were all apprehensive about the government's role in medicine. Many of us saw the PSRO as another form of unilateral government intrusion into our affairs.

The federal government, however, has some legitimate concerns about how their (our) health care dollars are spent. They have given physicians wide latitude in implementing this program so that we can do something about the problem. Local, community-based physicians are required if the system is going to be effective. Yet, the system cannot be objective unless sponsorship of peer review activities is external to the individual hospitals. Effective, objective, local and physician-directed — these adjectives apply.

Our own PSRO has sincere hopes of becoming a local resource rather than a bureaucratic ornament.

I would like to mention our special relationship with the hospitals in our area. We are one of only two PSROs in the country that regularly involves the local hospital administrators in the policy-making activities of the organization. Frankly, we are very pleased with the level of expertise and involvement that the hospital administrators have shown.

Area VII

Robert E. Medlar, MD
Jackson

Area VII PSRO is conditional and actively pursuing the goal of documenting the quality of care in our 15 hospitals. All but two have opted for delegated status, and most have systems in place and functioning. We are fortunate in having an active and hard-working board, dedicated committees and a top-notch staff.

We are zeroing in on the best way to ask the proper questions in order to accumulate the data which will be honest, and helpful in pointing out ways in which patient care in our hospitals may be improved. We are looking for ways to focus on the problem areas and avoid wasting time where problems do not exist.

We believe strongly that peer review must remain in the hands of physicians and are therefore facing the challenge of proving we can do an efficient job. Cost containment may be the primary goal of the government, but we are determined that quality of care will be our first priority. These may not be incompatible. Quality care includes as one of its many facets, efficient use of our talents and facilities. The difficult part will be to become more efficient, dollar wise, without diminishing quality.

We are increasingly aware that the overall task is much more complex than it at first appeared. We also know that if physicians don't make this review system work, no one can. But someone else will try!

Doctor Greene

Doctor Egleston

Doctor VanDuyne

Doctor Medlar

Area IX

Donald G. Blain, MD
Mt. Clemens

Area IX Oakland-Macomb PSRO has completed the first of three stages, planning, and has been funded by HEW in the amount of $698,058.00 in its second or conditional stage for the next 18 months. The Fully Operational stage will follow.

Current physician membership is 1,200 plus and still growing, providing well over the 25 percent of area physicians required to be representative. It is our feeling that physician-controlled peer review is paramount. To that end we seek the participation of all physicians in Oakland and Macomb counties.

Our present work involves a collaborative effort with hospitals to begin the acute review process through focusing on problem areas primarily. It is important to remember that PSRO — not Blue Cross/Blue Shield or the Michigan Department of Public Health — will become the determinant as to who gets paid for Medicare and Medicaid patients as such decisions impact medical necessity.

The formulation of criteria, standards, and norms by physicians is of great importance in evaluation of care rendered.

Hospital review coordinators have participated with the Oakland-Macomb PSRO in the design of a common worksheet/abstract to feed relevant information rapidly and uniformly into the computer. From this, for the first time, we will be able to document the excellence of health care in this area.

Doctor Smookler

Doctor Blain

Area X

Phillip B. Stott, MD
Kalamazoo

Michigan Area X PSRO (MAX) completed its planning activity and became a conditional PSRO on Oct. 1 An interim board of directors has served loyally and well since 1974. An election of a new board is occurring this month.

Meanwhile, staff has been assisting hospitals to attain a better understanding of what PSRO means for Area X as a whole and for their individual facility. On-site survey of utilization review activity will begin this month. The first group of hospitals will be undergoing PSRO-governed review before "spring planting."

We feel the hospitals in this area generally already are capable of doing the necessary task. MAX plans to build on the base of good review occurring in Area X. Consequently, we are expecting that most of our hospitals will be delegated to for review.

Our current objectives are:

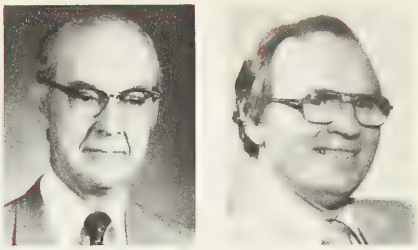
- To implement PSRO-governed review in 24 acute-care hospitals.
- To establish and implement a comprehensive program aimed at quality care.
- To implement alternative concurrent review systems such as severity of illness monitoring or focused review.

Our long-term objective is to assist physicians. We hope our organizational structure and activities will assist physicians to maintain or improve the quality of care delivered in our area. We can assist them and hospital administrations to make more efficient and effective use of the health care delivery system. By assisting in these efforts we will also be ensuring the appropriate use of health care dollars.

Doctor Stott

Area VIII PSRO is profiled on the next page.

Michigan's largest PSRO based in Wayne County



Doctor Cooper **Mr. Lang**

By C. R. Shelton
Special to **Michigan Medicine**

Wayne County's Professional Standards Review Organization, based in Detroit, is the largest of the 10 PSROs in the state and one of the largest in the entire country.

Its membership, about 3,990, includes 80 percent of the physicians in the county. It soon will review hospital in-patient care for approximately 150,000 Medicare, Medicaid, and Title V patients per year in the 51 short-term, general care hospitals within its area of jurisdiction.

It was created by a consortium of Wayne County Medical, Wayne County Osteopathic, and Detroit Medical Societies shortly after the national PSRO program was enacted. Its original governing board was composed of members from the three societies. The executive director, James Lang, was appointed on Jan. 1, 1976.

Organizational structure

Today, the PSRO is governed by a 38-member Board of Trustees, who are elected for a three-year term by ballots distributed to every physician member in Wayne County.

The day-to-day business of the organization is the responsibility of the executive committee which has 10 physician members. The committee meets at least monthly, and is the organization's only committee with decision-making powers.

The 22-person administrative staff includes nurses, data processing personnel, medical records processors, and business administrators. About half of the staff works in the field with hospital personnel.

This PSRO is funded, as all such organizations are, totally by the federal government, under a contract with HEW that calls for certain specific review procedures of all health care institutional services but with priority given to the review of hospital care.

Performance of PSROs is measured against the required activities, and continuation of operating funds is contingent upon the PSRO's performance.

Two views

Mr. Lang states the organizations are viewed in very different ways by the government — which supports them, and by physicians — who are responsible for their work.

"The government appears to see PSROs as a primary source and method of placing cost containment and controls in the health care delivery system," he says. "It feels that can be accomplished because PSROs can affect utilization rates by setting criteria on how health care services will be delivered.

"On the other hand, physicians value the PSROs because the organizations do establish a unified, primary focus by which the quality aspects of health care, area-wide, can be viewed and analyzed.

"Many physicians' basic beliefs about PSROs are that they are an extension of the profession's traditional method of self-assessment . . . the medical audit. Physicians in hospitals and other areas of health care have been auditing themselves for 30 or 40 years in a formal fashion. Medicine is probably the only profession in the United States which has done this in an organized, objective, and visible manner."

Mr. Lang believes the government feels that if PSROs do not work out as planned, the only alternative is for bureaucrats to take over PSRO duties now performed by physicians. Then the organizations would become part of a nationalized medicine system.

"Certainly, PSROs are not perfect and the entire concept is disquieting to some physicians. However, the organizations are much more acceptable than for the government to take over completely," he adds.

Unique cooperation

"Under PSRO, physicians and the government are in a unique position of cooperation and decisions are not made unilaterally by the government. The organizations offer what is probably the only national program involving almost an equal partnership between the private sector and the federal government.

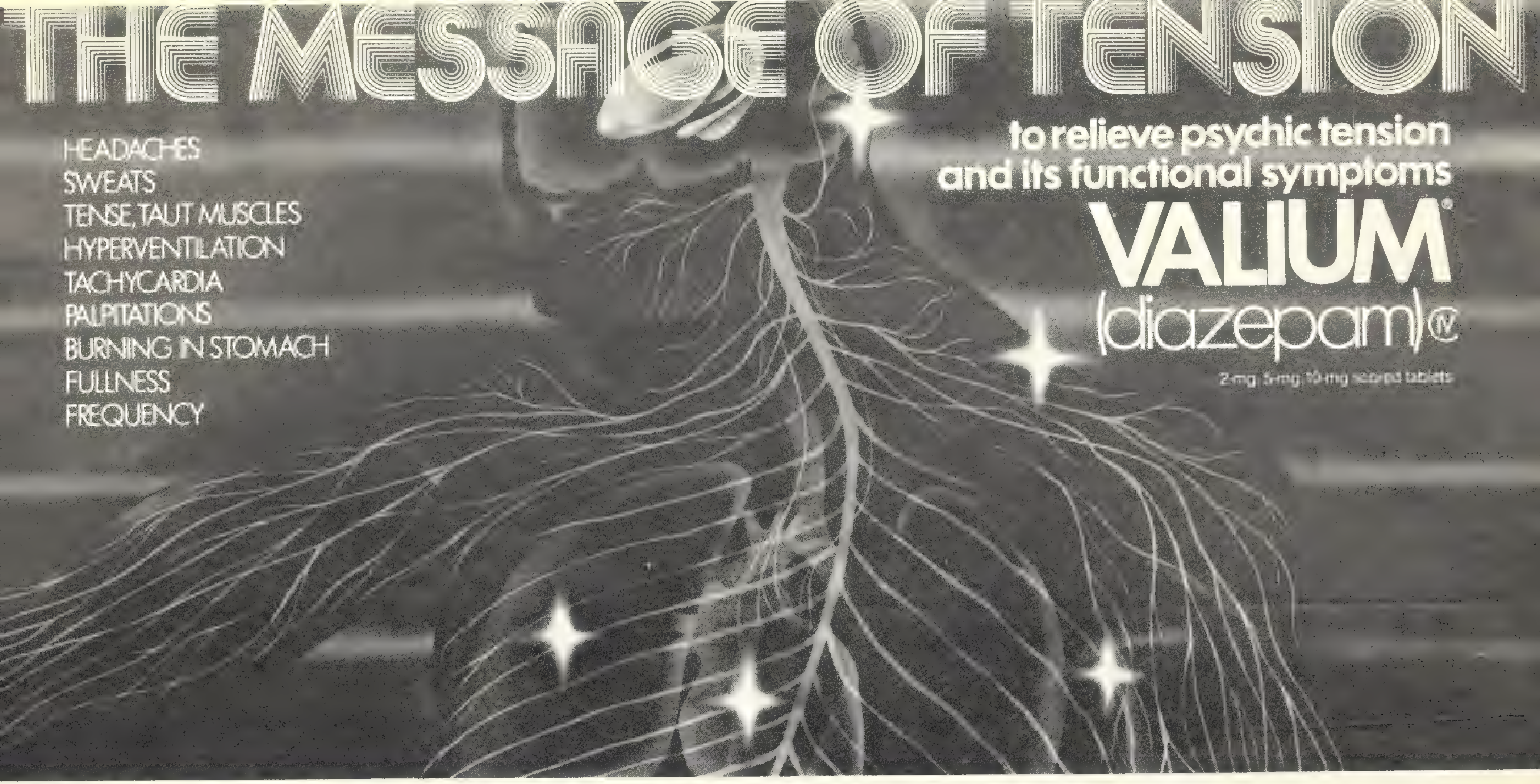
"While it is true that PSRO activities are largely overshadowed by the government, they do make physicians a cooperating partner in decisions and offer an effective, demonstrably clear path by which physicians can influence programs."

Ralph R. Cooper, MD, a Grosse Pointe specialist in internal medicine and gastroenterology, and board chairman of the Federation of Physicians which has contracted to perform the PSRO work in Wayne County, states that the organization's efforts are well underway.

"Since starting last June, we have activated binding reviews in one-fourth of the county's hospitals. We expect to have binding reviews in operation in the second one-fourth of the hospitals before the end of the year and in all of them by June of 1979," he says.

"Also, we are studying a focused review model in one hospital at the present time and probably will expand that type of review as time goes on."

Doctor Cooper adds "the government suggested innovative methods of study. We feel that we have come up with methods that are innovative and will for the first time in history tell by age, diagnosis, and sex, exactly how medicine is being practiced in this area. When we have that, we can hope to tell what changes, if any, need to be made."



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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient

Contraindicated: Known hypersensitivity to the drug Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating) Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation slurred speech, tremor, vertigo urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances stimulation have been reported should these occur discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy

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Opportunities are unlimited for MSMS, components' public service activities

By Mert Scholten
MSMS Communications Chief

A recent survey among the physicians serving this year as presidents of MSMS component medical societies indicated a strong interest in possible public service activities that might be undertaken successfully by county medical societies.

So, here are some ideas that members of component societies can advocate to component leaders; and hopefully members will volunteer to carry out these projects. (This list has been sent already to component presidents and some of the ideas are moving along already in the planning stages for 1979.)

"Why carry on public service projects," you ask?

Well, traditionally, trade and professional associations at the local, state and national level are organized to carry out two general purposes:

- To serve the members. Rightfully so, as the major reason for associations is to protect the special interests of the members.
- To serve the public.

In the medical field we are especially lucky because the public has great interest in good health and medical care. MSMS, throughout its 113 years of history, has conducted activities and projects to directly benefit the public — the people of Michigan.

Many other associations have great difficulty trying to identify with the everyday concerns of the people.

And the components, MSMS, AMA and the specialty societies are all lucky, too, because the physician member has a keen personal desire to serve the public — not only as a physician, but also as an educator, as a public-spirited citizen, as a community leader.

The opportunities are unlimited for public service activities for the component medical societies and MSMS and for our mutual members. Each community is different so the needs and interests there are different. Likewise, potential projects are different because of the component membership size, because of available funds, because of other member and public commitments.

MSMS constantly reviews the ongoing public service activities, so some can be dropped and new ones added. Different times demand different responses and initiatives.

* * *

The newest MSMS public service project is in the area of cost awareness. The MSMS Committee on Public Service — with Thomas C. Payne, MD, of Lansing as chairman — will publish a series of folders this year about medical costs. Copy for the first folder was approved by the MSMS Council in December. The folders are available at a charge just enough to cover printing costs. These folders can be placed in the doctor's office, in factories for union members, in supermarkets, etc. Only one's imagination limits the distribution.

Also regarding medical costs, MSMS has provided a standard speech that any member can use before service clubs, church groups and other organizations. At such talks,

Manning the phones for one of MSMS's newest public service projects is Peter McCabe, MD, Grosse Pointe Woods. The project is the "Call for Action — Ask the Doctor" program sponsored by WJR radio station in Detroit which answers the public's off-the-air questions about medical care, or refers them on to the proper aid.

Mert Scholten, Chief, MSMS Office of Communications & Public Service, taught journalism, mass media and communications courses on the high school level for 10 years prior to joining the MSMS staff. Holder of a master's degree in journalism, he spends a good deal of his time working with media reporters across Michigan and arranges the monthly television program "Housecall" on Ch. 56, Detroit. He is currently developing plans for strengthening relations and communications between MSMS and its components.

the folder will be a great take-home piece.

The November issue of *Michigan Medicine* contained a tent card about medical costs. The card describes the physician's concern about rising medical costs. Extra copies of this card are available to physicians and component societies wishing to push the project. The tent card is designed for the reception area of the doctor's office.

The AMA has many well-designed, tightly-written folders and booklets available that a component society, or a medical clinic, or an individual physician can order and use. For details write to the MSMS Department of Communications for samples and price lists.

* * *

Let us suggest some ways to use some of the popular AMA folders:

The AMA offers a Family Health Record booklet. Components or individual doctors can purchase these, add a sticker giving society name and address and distribute at "health fairs," to service clubs, to patients.

In the same line, the AMA has a folder, "You Need a Family Doctor Before Illness Strikes — Why Wait." Give copies to the library, the banks, for distribution.

Another AMA folder, "When to Call or See Your Physician" would interest many people, so offer copies through public service announcements over radio or TV stations.

There is great interest now in obesity and fad diets. You can buy copies of AMA folders — "The Healthy Way to Weight Loss" or "Your Age & Diet" and offer these through the beauty parlors and the barber shops.

For a copy of the AMA catalog of the many, many available health education materials, write to MSMS, or directly to the AMA, 535 N. Dearborn, Chicago 60610.

Here are 15 good ideas for public service projects

Here is a list of 15 suggestions for components and their public service committees to consider for 1979. MSMS staffers Mert Scholten and Herb Auer are ready to counsel and advise on any of these ideas and others.

1. Hold **public education forums** on diabetes, cancer or geriatric problems in cooperation with a local newspaper, radio or TV station.

2. Purchase **health career materials** for local school guidance departments.

3. Hold a **"Health-o-rama Day"** at a local shopping center, getting various health organizations and agencies to cooperate at booths and demonstrations.

4. Establish a local **speakers bureau** to provide speakers on selected subjects to civic groups.

5. Work with local TV or radio station to develop a program like **"Housecall"** where listeners or viewers can phone in questions to a panel of doctors.

6. Develop local system of **awards** to citizens for community contributions in health field.

7. Purchase space in local paper for periodic **health column** messages.

8. Work with Auxiliary to **promote awareness** of need for immunizations.

9. Sponsor **future physicians club** at local schools.

10. Purchase one **health book** per year for the local library. (Illustrated Atlas of Anatomy, Common Sense Health Guide, etc.)

11. Work with schools to provide medical care for **athletic events** insuring appropriate expertise on hand at all competitive events.

12. Develop a local **physician directory** on getting medical care.

13. Consider hiring a local journalism instructor as a free-lance, part-time assistant to your local society to develop local **public service efforts.**

14. Consider a $100 per year **scholarship** to local student pursuing a medically-related career — not necessarily as an MD, although it could be solely for that purpose.

15. Initiate local plans or support an already established project so that residents can dial a **"Tel-Med"** number and ask to hear a medical explanation of health problems.

MSMS members bustled about the Detroit Plaza Nov. 7-8-9 during the Annual Scientific Meeting.

Just one of the three big Annual Scientific Meetings days

How MSMS helped 100 faculty members provide 25 half-day courses for 1,300 physicians

Can you imagine the detailed planning and intricate procedures required for the MSMS Committee on CME Programming and the MSMS staff to teach 12 half-day courses for 549 physicians in the morning of one day, and then 13 different half-day courses for 756 doctors that afternoon? And to do this with more than 100 practicing physicians and medical school professors on the faculty for that one single day?

Well, it was done.

And it was done smoothly.

The day described above was Wednesday, Nov. 8 — the middle day of the three-day 1978 MSMS Annual Scientific Meeting at the Detroit Plaza.

During the three-day meeting, total attendance was 2,113 physicians, exhibitors and guests — topping the 1977 figures by 1,200.

The 58 Category I courses drew 1,604 physicians who enrolled for 3,500 places. The MSMS Committee for CME Programming awarded a total of 9,510 hours of Category I credit to MSMS members and other physicians.

Leaders draw praise

Once again the chairman for the entire project was Robert F. Wilson, MD, an assistant dean at WSU medical school. "Doctor Wilson served effectively as chairman for the Scientific Meetings in 1976, 1977 and 1978 and added depth to the new scientific meeting format of half-day courses rather than primarily general sessions," praises Carl F. Hammerstrom, MD, chairman of the MSMS CME Programming Committee.

The MSMS Council on Dec. 13 adopted a resolution thanking Doctor Wilson for his excellent leadership, and thanking also the 28 specialty societies and 21 medical school de-

Doctor Wilson

Speaker and course director Joseph Arends, MD, Detroit, right, answers questions following his talk on exercise and medicine.

partments for developing and conducting many of the courses. The Council also offered its deep appreciation to the 277 speakers and course directors, who contributed their knowledge without any reimbursement.

The MSMS Council also praised the MSMS staff for organizing the many details and carrying through with great style.

Planning for the 1978 meeting began in October of 1977 and the project ran six months ahead of the 1977 timetable. Doctor Wilson identified early many subjects that physicians wanted according to various surveys. Then medical school professors and highly-regarded practicing physicians were invited to serve as course directors. These men and women developed course descriptions and educational objectives, and then obtained the faculties.

Practical courses designed

Courses were offered to help practicing physicians with every day medical problems — and they filled quickly. These included such topics as "Dermatology for the Non-Dermatologist," "High Risk Pregnancies," "Management of Cancer," "Chronic Renal Failure," "Congestive Heart Failure," "Cardiac Arrhythmias" and others.

Attendance also was good at several new courses that focused on general matters, such as "Physicians and Their Families," "Alcohol and Medical Practice," and "Care in the September Years."

For the first time, the Scientific Meeting Committee offered a two-day, 16-hour course — in "Advanced Cardiac Life Support" and it filled fast.

The location for the 1978 meeting proved popular and a drawing card for many physicians and their spouses. The Detroit Plaza was chosen because the Dearborn Hyatt Regency is undergoing expansion now. The 1979 Scientific Meeting will be back at the Hyatt Regency, location for the successful 1976 and 1977 meetings.

1979 plans underway

Planning for the 1979 meeting is already well underway. Samuel M. McMahon, MD, Lansing, is the new general chairman. Doctor McMahon, who is vice chairman of the MSMS Committee for CME Programming, is associate professor of medicine at the MSU College of Human Medicine and medical director for Ingham Medical Hospital in Lansing.

Evaluations from the 1978 meeting are being studied carefully to help select courses for 1979 and to improve several aspects of the previous meetings. — HAA

Course topics the drawing card

The major drawing card for the 1978 Annual Scientific Meeting, according to the physicians who completed overall evaluations were "the topics covered by the 58 courses." Three of every four physicians checked a form saying the factor that convinced him or her to participate was "certain topics interested me."

Slightly more than half of the physicians turning in the evaluations said they attended because they could obtain Category I credits toward the mandatory CME requirements of the state. It is known also that many members of the Michigan Academy of Family Physicians attended because 44 courses had been approved for the coveted "prescribed credit" required by AAFP.

About one-half of the doctors said they came because "the cost was reasonable." MSMS members were charged only $12 for three-hour, half-day courses.

More Scientific Meeting articles on pages 14, 16, 17 and 18.

Accept no substitute for your professional judgment

As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, substitution laws make it more difficult to exercise that right. In many states, unless you specifically direct pharmacists to dispense your brand-name prescription as written, they may be required by law to substitute another drug for your brand-name prescription.

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Our committee plans scientific meeting.
You attend courses Nov. 13-15.

Samuel McMahon, MD, Chairman
1979 Annual Scientific Meeting
Michigan State Medical Society
120 West Saginaw Street
East Lansing, MI 48823

Dear Doctor McMahon,

At the 1979 Annual Scientific Meeting I would like CME courses on these medical problems or subjects:

Sincerely,

Your letter now will give
our committee course subject ideas
in time to plan the '79 meeting program.
Then helpful courses will be waiting for you and
2,000 others in Dearborn's Hyatt Regency Nov. 13-14-15.

Dr. Samuel McMahon
Committee Chairman

Help MSMS now to help you in 1979

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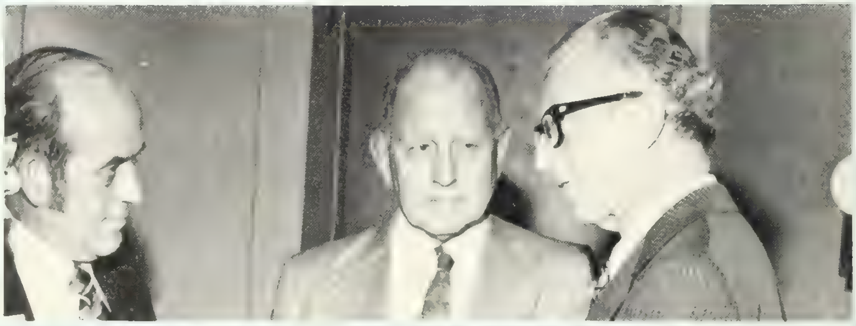

AMA President Tom E. Nesbitt, MD, right was guest at a reception in his honor following his presentation during the Annual Scientific Meeting. He meets, above, with Detroit-area MDs Kenneth J. Ray, and C. Jackson France.

Thousands of cups of coffee were dispensed at the scientific meeting by Joan Salinas, Lansing, medical assistants association state president, and her colleagues. Among the grateful physicians were speaker Vincent O'Conor, MD, of Chicago.

Photo highlights of 1978 MSMS Annual Scientific Meeting Nov. 7-8-9, Detroit Plaza Hotel

The Detroit Plaza, with its unique architecture, provided an interesting backdrop to physicians' meetings and casual discussions.

Long-time exhibitors like the Hack Shoe Company received special awards at the 1978 event. Stopping by for a chat with Morton Hack, left, is MSMS CME Programming Committee Chairman Carl F. Hammerstrom, MD.

Wayne State University Medical Alumni staged a reception Wednesday evening during the scientific meeting. Among the guests were, from left, Marjorie Peebles-Meyers, MD, Detroit; Doctor Peebles-Meyers' husband, the Rev. Canon F. Ricksford Meyers and Marion G. McCall, MD, Detroit.

The special session Wednesday afternoon on medical cost containment drew a good crowd. (See next page.)

ASM cost containment session had AMA, MSMS, hospital views

By Nancy E. Perkin
***Special to* Michigan Medicine**

While meeting rooms throughout Detroit's Plaza Hotel buzzed with the familiar lingo of clinicians, physicians in the Marquette Suite discussed a different kind of "emergency."

It was the urgency of rising health care costs that brought together physicians and leaders in organized medicine at the first annual Michigan State Medical Society meeting on cost awareness and medical care. The course, sponsored by the MSMS Committee on Medical Care Costs and scheduled for the midpoint of the state society's Annual Scientific Meeting, served to remind all participants of the importance of cost consciousness in the clinical setting.

Course director Charles R. Zimont, MD, of Constantine, in opening remarks stressed the meteoric rise of health care costs in recent years, and suggested that physician education may help to curb the increase.

"Physicians are managers of patient care, and thus should learn about costs in order to become more effective 'purchasing agents,' " said Doctor Zimont. "It is our hope that meeting today in an open forum may help to stimulate thoughts about costs and give us some idea of what is being done and what we might do to contain costs."

Panel members generally agreed that inflation and heightened demand for services have been the major culprits in pushing costs upward. But what can be done?

AMA viewpoint

Keynote speaker Tom E. Nesbitt, MD, a Tennessee urologist and newly elected president of the AMA, cited two possible solutions. The now familiar voluntary effort on cost containment, which aims to reduce health care costs by two percent each year for two years, is "only a short-term approach."

"The voluntary effort is an example of the Carter Administration's hypocritical, cynical, arrogant approach to the problem. The Administration has failed to acknowledge that medical care, the nation's third largest industry, already is implementing the wage and price restraints asked of other industries."

A long-range victory requires a two-pronged attack, according to Doctor Nesbitt.

"We must first create cost consciousness in everyone — both in the medical profession and outside of it. The public is generally unaware of cost consciousness, and it becomes our responsibility to orient our patients along the lines of cost containment. And then we must let the free market operate. Of course, crucial to success is developing self restraint within medical care."

Important first steps have been taken by the AMA to meet the goal of public education. Doctor Nesbitt noted that AMA representatives have met with leaders of 32 major corporations and with the editorial boards of prominent newspapers to "establish a dialog so they don't think doctors are self serving. Our approach has been and must continue to be positive rather than negative. We can't afford to be defensive if we want to continue to deal with industry."

Doctor Nesbitt's closing remarks were met with enthusiasm by course participants: "The only way we can continue to practice medicine in a free environment is to continue to be responsive to the needs of the people . . . I don't want anybody coming into my hospital and telling me how to practice medicine. And neither do you."

Doctor Heideman speaks

MSMS President Heideman, a Detroit pediatrician, presented a more philosophical approach to the problem. Stressing the crisis orientation of medicine, Doctor Heideman said, "Just as when treating a child, it's usually a waste of time to anticipate long-range health care plans . . . The government has spent millions on long-range planning . . . much of which has been discarded."

An effective answer to medical cost problems may be enhanced communication between doctors and patients. "Most patients like their own doctor but not doctors in general," he said. "We must build their trust so that we can all work together."

In hospital setting

Cost containment in the hospital setting received special consideration from the afternoon's concluding speakers.

In a thorough and often humorous account, Luis A. Tomatis, MD, a noted cardiovascular surgeon at Butterworth Hospital in Grand Rapids, explained how his surgical team has drastically reduced the cost of open heart surgery. By comparing techniques and regimens, the doctors developed a system of "expense rationalization" that has enabled them to reduce time, effort, and expenses.

John C. Bay, president of the Michigan Hospital Association and administrator of Munson Hospital in Traverse City, provided additional insight into hospital expenses in his talk entitled "Sensitivity to Health Care Costs: The Need for Physician and Hospital Cooperation Has Never Been Greater."

"Cooperation is the key to continued improvements of health care in the community," Doctor Bay summarized. "And education — of the public, of the medical staff, and of the hospital's administration — is the key to achieving cooperation."

Practical suggestions

A summary sheet prepared by the MSMS Task Force on Medical Care Costs offers practical suggestions for curtailing costs:

1. Learn hospital costs;
2. Teach cost awareness;
3. Limit diagnostic tests;
4. Reduce hospital utilization;
5. Discourage patient demands; and
6. Find out where you can cut costs and communicate with others.

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INDICATION: CONTRACEPTION. The pregnancy rate in women using conventional combination oral contraceptives (containing 35 mcg or more of ethinyl estradiol or 50 mcg or more of mestranol) is generally reported as less than one pregnancy per 100 woman-years of use. Slightly higher rates (somewhat more than one pregnancy per 100 woman-years of use) are reported for some combination products containing 35 mcg or less of ethinyl estradiol, and rates on the order of three pregnancies per 100 woman-years are reported for the progestogen-only oral contraceptives. Table 1 gives ranges of pregnancy rates reported in the literature for other means of contraception. The efficacy of these means of contraception (except the IUD) depends upon the degree of adherence to the method
Table 1: Pregnancies Per 100 Women-Years. IUD, less than 1-6; Diaphragm with spermicidal product (creams or jellies), 2-20; Condom, 3-36; Aerosol foams, 2-29; Jellies and creams, 4-36; Periodic abstinence (rhythm) all types, less than 1-47; 1 Calendar method, 14-47; 2. Temperature method, 1-20; 3. Temperature method—intercourse only in postovulatory phase, less than 1-7; 4. Mucus method, 1-25; No contraception, 60-80. **DOSE-RELATED RISK OF THROMBOEMBOLISM FROM ORAL CONTRACEPTIVES:** Two studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. For this reason, it is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive product prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance. It is recommended that new acceptors of oral contraceptives be started on preparations containing .05 mg or less of estrogen
CONTRAINDICATIONS: Oral contraceptives should not be used in women with any of the following conditions: 1. Thrombophlebitis or thromboembolic disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.
The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely than nonusers to develop these diseases without evident cause. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age
CEREBROVASCULAR DISORDERS: In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4.0 to 9.5 times greater in users than in nonusers
MYOCARDIAL INFARCTION: An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group In terms of relative risk, it has been estimated that oral contraceptive users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are also smokers have about a 5-fold increased risk of fatal infarction compared to users who do not smoke, but about a 10-to 12-fold increased risk compared to nonusers who do not smoke. Furthermore, the amount of smoking is also an important factor. In determining the importance of these relative risks, however, the baseline rates for various age groups must be given serious consideration. The importance of other predisposing conditions mentioned above in determining relative and absolute risks has not as yet been quantified; it is quite likely that the same synergistic action exists, but perhaps to a lesser extent **Risk of Dose:** In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Careful epidemiological studies to determine the degree of thromboembolic risk associated with progestogen-only oral contraceptives have not been performed. Cases of thromboembolic disease have been reported in women using these products, and they should not be presumed to be free of excess risk The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events **ESTIMATE OF EXCESS MORTALITY FROM CIRCULATORY DISEASES:** A large prospective study carried out in the United Kingdom estimated the mortality rate per 100,000 women per year from diseases of the circulatory system for users and nonusers of oral contraceptives according to age, smoking habits, and duration of use. The overall excess death rate annually from circulatory diseases for oral contraceptive users was estimated to be 20 per 100,000 (ages 15-34—5/100,000; ages 35-44—33/100,000; ages 45-49—140/100,000), the risk being concentrated in older women, in those with a long duration of use, and in cigarette smokers. It was not possible, however, to examine the interrelationships of age, smoking, and duration of use, nor to compare the effects of continuous versus intermittent use. Although the study showed a 10-fold increase in death due to circulatory diseases in users for five or more years, all of these deaths occurred in women 35 or older. Until larger numbers of women under 35 with continuous use for five or more years are available, it is not possible to assess the magnitude of the relative risk for this younger age group. This study reports that the increased risk of circulatory diseases may persist after the pill is discontinued. Another study published at the same time confirms a previously reported increase of mortality in pill users from cardiovascular disease. The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. The findings of this analysis are shown in Figure 1 below The study concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke. (The rates given for pill only/smokers for each age group are for smokers as a class. For "heavy" smokers [more than 15 cigarettes a day], the rates given would be about double; for "light" smokers [less than 15 cigarettes a day], about 50 percent.) The mortality associated with oral contraceptive use in nonsmokers over 40 is higher than with any other method of contraception in that age group. The lowest mortality is associated with the condom or diaphragm backed up by early abortion. The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia and especially by cigarette smoking. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended. Based on the data currently available, the following chart gives a gross estimate of the risk of death from circulatory disorders associated with the use of oral contraceptives

SMOKING HABITS AND OTHER PREDISPOSING CONDITIONS—RISK ASSOCIATED WITH USE OF ORAL CONTRACEPTIVES

Age	Below 30	30-39	40+	
Heavy smokers	C	B	A	A—Use associated with very high risk.
Light smokers	D	C	B	B—Use associated with high risk
Nonsmokers (no predisposing conditions) .	D	C,D	C	C—Use associated with moderate risk
Nonsmokers (other predisposing conditions).	C	C,B	B,A	D—Use associated with low risk

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately. A four- to six-fold increased risk of postsurgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization. 2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures. 3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. Certain synthetic progestogens, none currently contained in oral contraceptives, have been noted to increase the incidence of mammary nodules, benign and malignant, in dogs. In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. Of the cases found in women without predisposing risk factors for adenocarcinoma of the endometrium (e.g., irregular bleeding at the time oral contraceptives were first given, polycystic ovaries), nearly all occurred in women who had used a sequential oral contraceptive. These products are no longer marketed. No evidence has been reported suggesting an increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives. Several studies have found no increases in breast cancer in women taking oral contraceptives or estrogens. One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in the subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented. In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

Figure 1. Estimated annual number of deaths associated with control of fertility and no control per 100,000 nonsterile women, by regimen of control and age of woman.

	15-19	20-24	25-29	30-34	35-39	40-44
No method	5.5	5.2	7.1	14.0	19.3	21.9
Abortion only	2.3	2.5	2.5	5.2	9.8	6.6
Pill only-nonsmokers	1.3	1.4	1.4	2.2	4.5	3.1
Pill only-smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUDs only	1.1	1.2	1.2	1.4	1.6	1.4
Traditional contraception only	1.1	1.4	1.9	3.7	4.7	4.0
Traditional contraception and abortion	0.3	0.4	0.4	0.8	1.4	0.8

4. HEPATIC TUMORS Benign hepatic adenomas have been found to be associated with the use of oral contraceptives. One study showed that oral contraceptive formulations with high hormonal potency were associated with a higher risk than lower potency formulations. Although benign, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives. Two studies relate risk with duration of use of the contraceptive, the risk being much greater after four or more years of oral contraceptive use. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass or shock. A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time. 5. USE IN OR IMMEDIATELY PRECEDING PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated to be on the order of 1 to 4 in 1000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Male children so exposed may develop abnormalities of the urogenital tract. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes. An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of sex hormones, including oral contraceptives, in pregnancy. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend three months although no precise information is available on which to base this recommendation. The administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy. 6. GALLBLADDER DISEASE. Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives and estrogens. In one study, an increased risk appeared after two years of use and doubled after four or five years of use. In one of the other studies, an increased risk was apparent between six and twelve months of use. 7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives. An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives. 8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives. Hypertension that develops as a result of taking oral contraceptives usually returns to normal after discontinuing the drug. 9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause. 10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. If pathology has been excluded, time or a change to another formulation may solve the problem. Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease. Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods. Postuse anovulation, possibly prolonged, may also occur in women without previous irregularities. 11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. 12. BREAST FEEDING Oral contraceptives given in the postpartum period may interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The effects, if any, on the breast-fed child have not been determined. If feasible, the use of oral contraceptives should be deferred until the infant has been weaned **PRECAUTIONS: General:** 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug-related. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, asthma, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives: a. Increased sulfobromophthalein retention. b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. c. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered. d. Decreased pregnanediol excretion. e. Reduced response to metyrapone test **INFORMATION FOR THE PATIENT: (See Patient Package Insert). DRUG INTERACTIONS:** Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin **CARCINOGENESIS, PREGNANCY, NURSING MOTHERS: See CONTRAINDICATIONS and WARNINGS. ADVERSE REACTIONS:** An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS): Thrombophlebitis. Pulmonary embolism. Coronary thrombosis. Cerebral thrombosis. Cerebral hemorrhage. Hypertension. Gallbladder disease. Liver tumors. Congenital anomalies. There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: Mesenteric thrombosis. Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis. The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug-related: Nausea, usually the most common adverse reaction. Vomiting, occurs in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally. Gastrointestinal symptoms (such as abdominal cramps and bloating). Breakthrough bleeding Spotting. Change in menstrual flow. Dysmenorrhea. Amenorrhea during and after treatment. Temporary infertility after discontinuance of treatment. Edema. Chloasma or melasma which may persist. Breast changes: tenderness, enlargement, and secretion. Change in weight (increase or decrease). Change in cervical erosion and cervical secretion. Possible diminution in lactation when given immediately postpartum. Cholestatic jaundice. Migraine. Increase in size of uterine leiomyomata. Rash (allergic). Mental depression. Reduced tolerance to carbohydrates. Vaginal candidiasis. Change in corneal curvature (steepening). Intolerance to contact lenses. The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted Premenstrual-like syndrome. Cataracts. Changes in libido. Chorea. Changes in appetite. Cystitis-like syndrome. Headache. Nervousness. Dizziness. Hirsutism. Loss of scalp hair. Erythema multiforme. Erythema nodosum. Hemorrhagic eruption. Vaginitis. Porphyria. Impaired renal function. (ORTHO-NOVUM 1/50□21 and ORTHO-NOVUM 1/50□28 contain tartrazine. Allergic reactions have been reported with the ingestion of this dye in some patients.) **ACUTE OVERDOSE:** Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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Michigan Medicine makes points about growth of family practice

The November issue of *Michigan Medicine*, featuring a special section on family practice medicine in this state, has received wide play.

The journal cover was an attractive four-color photo of a family physician and his young patient. The photo was provided by the American Academy of Family Physicians.

Inside, the lead article described the efforts of the Michigan Academy of Family Physicians to encourage more medical students to enter family practice. Other articles featured each of the family practice departments of Michigan's three medical schools.

A copy of the issue was sent to 15 medical writers for newspapers around the state, with a note from Mert Scholten, MSMS coordinator of media relations. Mr. Scholten offered assistance in any stories the writers might wish to develop from the journal articles.

Added Mr. Scholten:

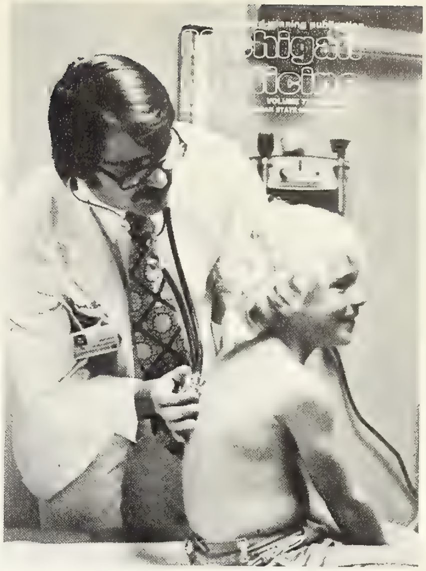
"Despite the often heard complaint of 'I just can't get a doctor' it should be noted that family practice is still the largest specialty group in Michigan with approximately 2,400-2,500 doctors — and the numbers are growing steadily as the 20 residency programs continue to train and graduate more family practice specialists.

"The planned geographic spread of the programs should do a great deal to alleviate the primary care shortage in many of the underserved areas since experience has shown that most residents tend to set up practice within 50-100 miles of their training site.

"While the distribution of physicians may still be a problem in some areas of Michigan, it is encouraging to know that positive steps are being taken to deal with the situation — and the accompanying articles point out some of those steps and efforts.

"The following cities and/or hospitals currently have family practice residency programs:

Ann Arbor — University of Michigan,
Battle Creek — Cooperative,
Dearborn — Oakwood Hospital,
Detroit — Harper Grace Hospital,
Detroit — Mt. Carmel Hospital,
Detroit — St. Johns Hospital,
Escanaba — UPMEP,
Flint — St. Joseph Hospital,


AAFP PHOTO

Grand Rapids — GRAMEC,
Grosse Pointe — Bon Secours,
Kalamazoo — SMAHEC,
Lansing — St. Lawrence Hospital — MSU,
Lansing — Sparrow Hospital,
Midland — Midland Hospital Center,
Pontiac — Pontiac General,
Pontiac — St. Joseph Mercy,
Saginaw — Cooperative Program,
Southfield — Providence Hospital."

Michigan Medicine *leads in number of national ad pages*

By James H. Tisdel, MD
Port Huron

How highly do pharmaceutical advertisers value *Michigan Medicine*?

Do pharmaceutical advertisers feel that MSMS members read *Michigan Medicine* each month?

The answers to those questions are contained in the statistical report that *Michigan Medicine* regularly carries the third highest number of pages of national pharmaceutical advertising among the state journal group.

The average number of national ad pages in five publications listed by the State Medical Journal Advertising Bureau are as follows:

28 pages — *JAMA*
27 pages — New England
25 pages — Texas
24 pages — Florida
23 pages — *Michigan Medicine*

It is interesting to members of the MSMS Publication Committee that *Michigan Medicine* regularly carries more national pharmaceutical advertising than the state society publications for New York, Ohio, Illinois and Pennsylvania — all journals with larger circulations than the MSMS journal.

At a recent conference of state medical society journals in Louisville, graphic designers pointed out reasons why *Michigan Medicine* was judged by Sandoz Pharmaceuticals as the best designed, best written state journal in the nation.

As chairman of the MSMS Publication Committee, I want to praise Judy Marr and Herb Auer for the great job they do in presenting articles that are of special interest and value to Michigan physicians — and all in a very appealing format.

Doctor Tisdel is chairman of the MSMS Committee on Publications, and is vice chairman of the MSMS Council.

'Superstars' to key presentations at 1979 Maternal Health Conference

By Willah Weddon
Special to **Michigan Medicine**

Top-notch speakers from around the nation, specialists in their fields, will discuss topics of current interest during the 18th Annual Michigan Conference on Maternal and Perinatal Health, February 28 and March 1 at the Hyatt Regency, Dearborn.

The two-day conference, sponsored by MSMS and nine other organizations, has been coordinated into four half-day sessions. Physicians can attend any one session, but it is hoped they will plan to be present during the entire conference to take advantage of this educational opportunity. A total of 11 Category I credits is available.

Consistently popular through the years, this conference is expected to break all attendance records with the theme, "Perinatal Perspectives," which was selected within weeks after the close of the 1978 event.

Filling educational needs

"Where can we do the most good, educationally?" has been the key question in a series of program planning committee meetings conducted by co-chairmen Bruce A. Work, Jr., MD, Ann Arbor, and John W. Hallitt, MD, Flint. The 22-member committee, composed of physicians and nurses providing state-wide representation, based much of their effort on filling needs suggested by comments on evaluation sheets from the previous conference.

"You have to have good speakers to have a successful meeting," Doctor Work stressed in one of the typical planning sessions. He stood, chalk in hand, ready to diagram each segment of the conference on a blackboard as the meeting progressed.

Doctor Work at 1978 Maternal Health Conference.

No one disagreed with him on this. Statistics for the '78 conference clearly illustrated the fact that good speakers had cost more (almost double), but an increased attendance had covered the additional expense. Over 850 doctors, nurses, house officers, and students attended the 1978 conference.

"We need experts in their field who can present information in an interesting manner," Doctor Work continued as he filled in the first time-block, "The High Risk Obstetrical Patient." This had been one of the most frequently recommended topics on evaluation sheets so was given priority and slotted for Wednesday morning.

Ideas and suggestions began to come from all directions around the table. Moving quickly from one person to the next, Doctor Work adroitly meshed the information into program format.

'Superstar' format planned

Each session will open with a superstar" speaking for 45 minutes. This is to be followed by typical case histories to be presented, in turn, by an obstetrician, a family physician, and a nurse. Each history will be discussed in depth by all members of the panel and the superstar, with input from the audience encouraged. The session will end with a recap and summarization by the superstar.

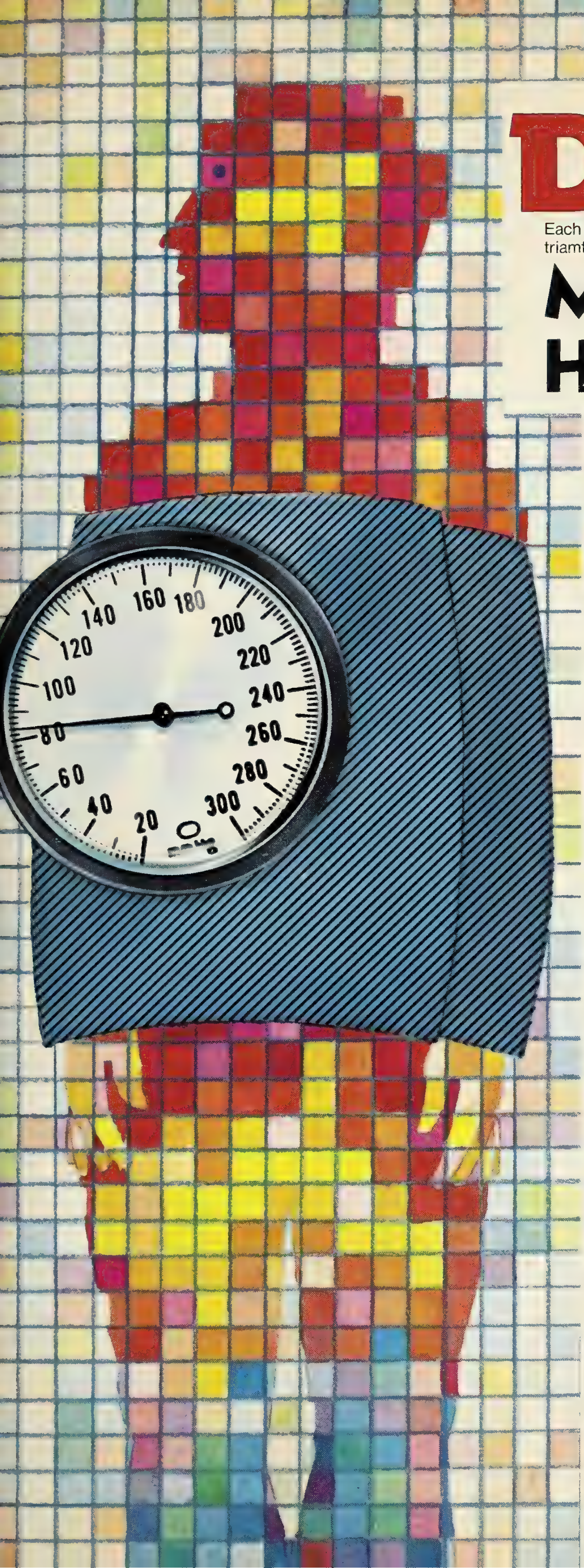
"High Risk Pediatric Patient: Identification and Stabilization," is the subject of Wednesday afternoon's session, using the same format as in the morning, combining the talents of a super star embellished by the mind teasing case histories introduced by a panel of experts.

"Back Transfer and Followup" kicks off the Thursday morning session, followed by presentations on "Genetic Screening for Mental Retardation," "Infant Bonding," and other topics of current interest, discussed by nationally known experts in these fields. Speakers representing other interests will be high-lighted Thursday afternoon. The latter section, based on consideration of the fact that most attendees stay for the entire two days and might welcome a change of pace, includes a variety of issues. To conclude the meeting, a well-known speaker from the news media is planned.

A positive step in obtaining continuing educational credits or "contacts" for nurses attending the conference is the co-sponsorship of the Michigan Nurses Association. MNA accreditation is still being pursued at the time of publication.

Arrangements are being completed in similar, subsequent meetings, sparkling with stimulating ideas designed to create the best Michigan Conference on Maternal and Perinatal Health in history.

Doctor Hallitt



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Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

> * Warning
> This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

When painful spasm
is the presenting
symptom...

. . in functional G.I. disorders*

Bentyl®

(dicyclomine hydrochloride USP)

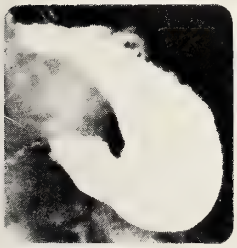
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

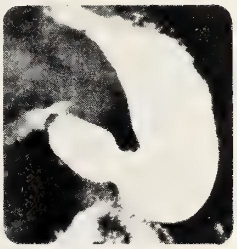
Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-3497 (Y515A)

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INDICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer.
IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective.

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon)

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with autonomic neuropathy, hepatic or renal disease; ulcerative colitis–Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis) Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia, palpitations; mydriasis; cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness; weakness, dizziness, insomnia; nausea, vomiting; impotence, suppression of lactation; constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs

Usual Dosage Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water) Bentyl 20 mg. *Adults* 1 tablet three or four times daily Bentyl Injection *Adults* 2 ml. (20 mg) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used

Product Information as of October, 1976

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati Ohio 45215 U S A

Meetings

Calendar of coming meetings

Jan. 18 — Michigan Ophthalmological Society, Wayne County Medical Society headquarters, contact: Helen Schulte, MSMS headquarters.

Jan. 24 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 24 — MSMS Auxiliary mid-winter board meeting, MSMS headquarters, contact Helen Schulte, MSMS headquarters.

Feb. 2-4 — American Association of Medical Assistants Mid-Winter Seminar, Jackson, contact: Helen Schulte, MSMS headquarters.

Feb. 15 — Michigan Ophthalmological Society, Wayne County Medical Society headquarters, contact: Helen Schulte, MSMS headquarters.

Feb. 20-21 — MSMS Practice Management Workshop, "Establishing Yourself in Private Practice," for residents, Lansing, contact: John Richards, MSMS headquarters.

Feb. 22-23 — MSMS Practice Management Workshop, "Establishing Yourself in Private Practice," for residents, Detroit, contact: John Richards, MSMS headquarters.

Feb. 28-March 1 — MSMS Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

March 4 — Medical Assistants Board Meeting. MSMS headquarters, contact: Helen Schulte, MSMS headquarters.

March 7 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 15 — Michigan Ophthalmological Society, Frankenmuth, contact: Helen Schulte, MSMS headquarters.

April 10 — MSMS Auxiliary Legislative Day, Kellogg Center, East Lansing, contact: Helen Schulte, MSMS headquarters.

April 12 — MSMS Conference on Medical Aspects of Organized Athletics, Towsley Center, Ann Arbor, contact: Mert Scholten, MSMS headquarters.

April 26-29 — Medical Assistants State Convention, Lansing, contact: Helen Schulte, MSMS headquarters.

May 4-6 — MSMS Auxiliary Annual Convention, Sheraton Inn, Kalamazoo, contact: Helen Schulte, MSMS headquarters.

May 4-5-6 — MSMS House of Delegates, Kalamazoo Center Inn, Kalamazoo, contact: Richard Campau, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting. Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

MSMS survey shows Detroit area gaining in percentage of malpractice suits

By John A. Richards, Chief
MSMS Bureau of Economics

The MSMS Bureau of Economics has collected the following information on 385 Michigan malpractice claims which completed the legal process between December, 1977 and August, 1978. This report is a continuation of a series of summaries conducted by the MSMS Bureau since March, 1977. Earlier summaries have been published in the June, 1977 and May, 1978 issues of *Michigan Medicine.*

As the previous Bureau reports have indicated, the types of settlements and the characteristics of the physician population being sued remain relatively constant.

The geographic distribution of counties where suits have been filed has changed slightly, with Wayne and Oakland counties reporting an increase in closed cases.

The majority of the suits continues to arise from incidents in the hospital or the physician's office. The relative distribution of suits against foreign medical graduates and board certified physicians has not shown significant change.

Type of settlement has remained relatively constant with the majority of the claims settled before going to trial. This category accounts for most of the total dollar awards.

General surgery, obstetrics-gynecology, and general practice/minor surgery are the three specialties most often involved in litigation.

One trend which seems to be developing is that there are fewer suits settled for less than $5,000. In the first MSMS survey, settlements under $5,000 represented 64.8 percent of all suits settled, while this percentage has decreased to 40.0 percent in the present survey. The category between $5,001 and $25,000 has shown the highest percentage increase.

Plaintiff's Type of Practice	**As of March '77**		**March-Nov '77**		**Dec '77-Aug '78**	
Institution	17	3.2%	2	.7%	3	.8%
P.C. or partnership	121	22.8	32	11.1	149	38.8
Self-employed	373	70.4	240	83.0	196	51.0
Employed MD	19	3.6	15	5.2	36	9.4
Total	530	100.0%	289	100.0%	384	100.0%

Plaintiff Board Certified?	**March-Nov '77**		**Dec '77-Aug '78**	
Yes	143	51.8%	225	60.3%
No	133	48.2	148	39.7
Total	276	100.0%	373	100.0%

Specialty	**As of March '77**		**March-Nov '77**		**Dec '77-Aug '78**	
General surgery	113	21.4%	59	20.7%	50	13.0%
Obstetrics-gynecology	98	18.6	62	21.8	65	16.9
General practice — minor surgery	62	11.7	14	4.9	43	11.2
General practice	49	9.3	35	12.3	16	4.1
Orthopedic surgery	44	8.3	22	7.7	31	8.0
Internal medicine	21	4.0	13	4.6	28	7.3
Anesthesiology	19	3.6	7	2.5	5	1.3
Otolaryngology	18	3.4	6	2.1	2	.5
Urological surgery	13	2.5	4	1.4	8	2.1
Pediatrics	10	1.9	10	3.5	10	2.6
Neurological surgery	10	1.9	3	1.0	11	2.8
Psychiatry	10	1.9	6	2.1	3	.8
Thoracic surgery	8	1.5	4	1.4	8	2.1
Ophthalmology	7	1.3	4	1.4	1	.3
Emergency medicine	7	1.3	0	0	8	2.1
Plastic surgery	6	1.1	3	1.0	6	1.6
All other	33	6.3	33	11.6	90	23.4
Total	528	100.0%	285	100.0%	385	100.1%

	March-Nov '77		**Dec '77-Aug '78**	
Number of Cases with No Indemnity Paid	95/290	32.8%	158/385	41.0%

Caution is advised in interpreting the results of these surveys. The information contained in these reports must be considered in conjunction with all other available data on this subject.

The MSMS Bureau of Economics wishes to thank the personnel of the Michigan Department of Licensing and Regulation for their assistance in compiling this information.

Technical Note:

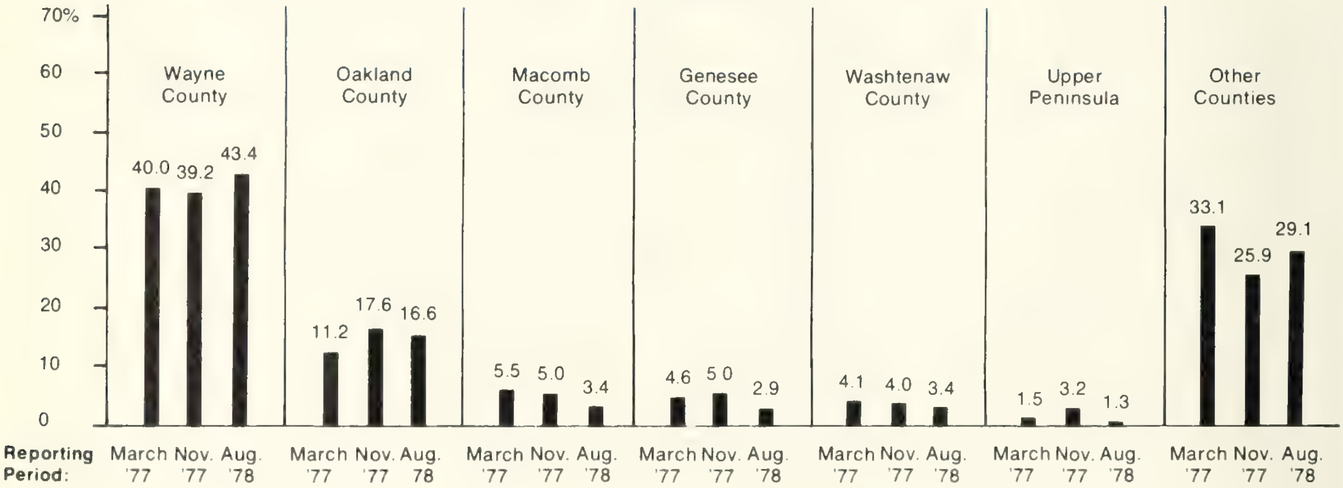
Due to incomplete answers, the findings will not total the same for each specific data element. Also, the rounding of percentages accounts for the totals not consistently adding up to 100.

See following pages for further breakdowns.

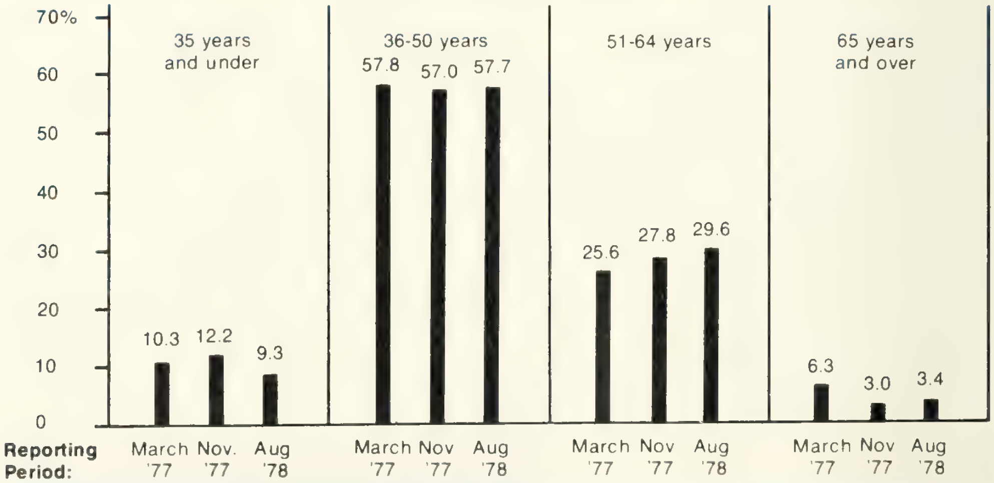
	Number of Claims		**Percentage of Total Claims**		**Average Amount of Claims**	
	11/77	***8/78***	***11/77***	***8/78***	***11/77***	***8/78 Claims with Indemnity Pd.***
Wayne, Oakland, and Macomb	172	244	61.9	63.4	$21,345	$17,025
Other Lower Peninsula Counties	97	136	34.9	35.3	23,880	20,975
Upper Peninsula	9	5	3.2	1.3	7,222	7,500
	278	385	100.0	100.0	$52,447	$45,500

Note: Wayne, Oakland, and Macomb Counties represent 52.5% of the Michigan MD population. The other counties in the Lower Peninsula account for 45.6%, and the Upper Peninsula for 1.9%.

County of suit



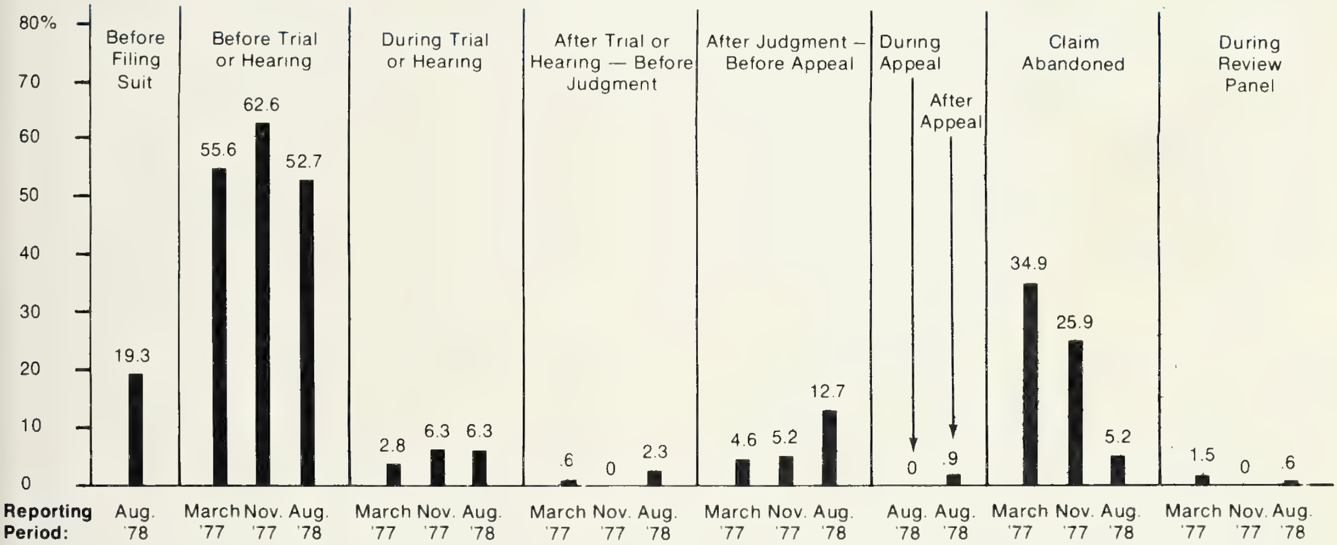
Physician's age



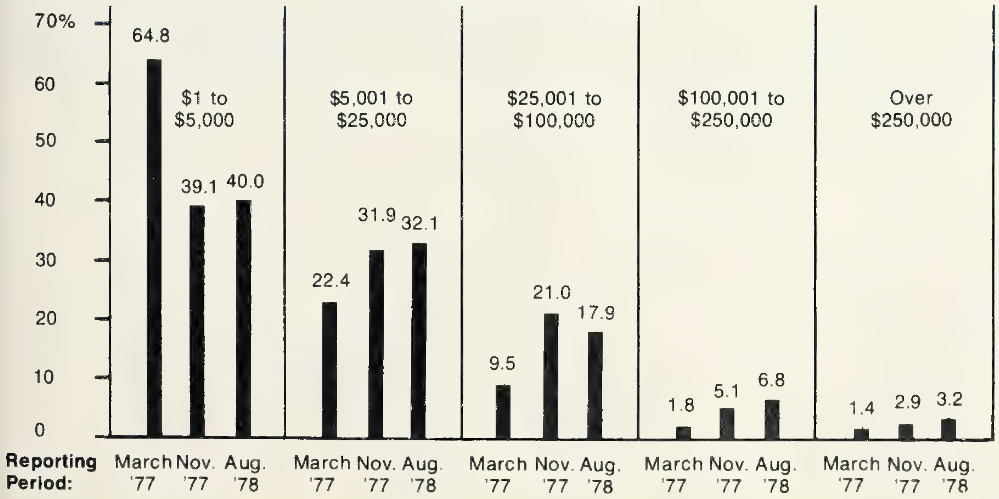
Type of Settlement	Number of Cases			Total Indemnity Paid			Average Payment to Defense Counsel		
	3/77	11/77	8/78	3/77	11/77	8/78	3/77	11/77	8/78
1. Before filing suit or demanding arbitration hearing	—	—	67	—	—	$3,080,364	—	—	$2,031
2. Before trial or hearing	262	179	183	$5,183,535	$3,187,594	3,463,650	$1,563	$1,898	1,841
3. During trial or hearing	15	18	22	354,670	2,131,250	1,080,900	7,359	5,878	3,891
4. After trial or hearing, but before judgment or decision (award)	3	0	8	85,000	—	98,500	16,654	—	5,577
5. After judgment or decision, but before appeal	23	15	44	272,711	203,598	3,000	4,779	4,475	2,256
6. During appeal	—	—	0	—	—	—	—	—	—
7. After appeal	—	—	3	—	—	2,500	—	—	1,997
8. Claim or suit abandoned by plaintiff	165	74	18	1,515,534	551,200	0	1,113	1,343	515
9. During review panel or non-binding arbitration	8	0	2	68,000	—	25,000	7,889	—	588
Totals	476	286	347	$7,479,450	$6,073,642	$7,753,914*			

* *An additional $37,738 was paid for unspecified types of settlements.*

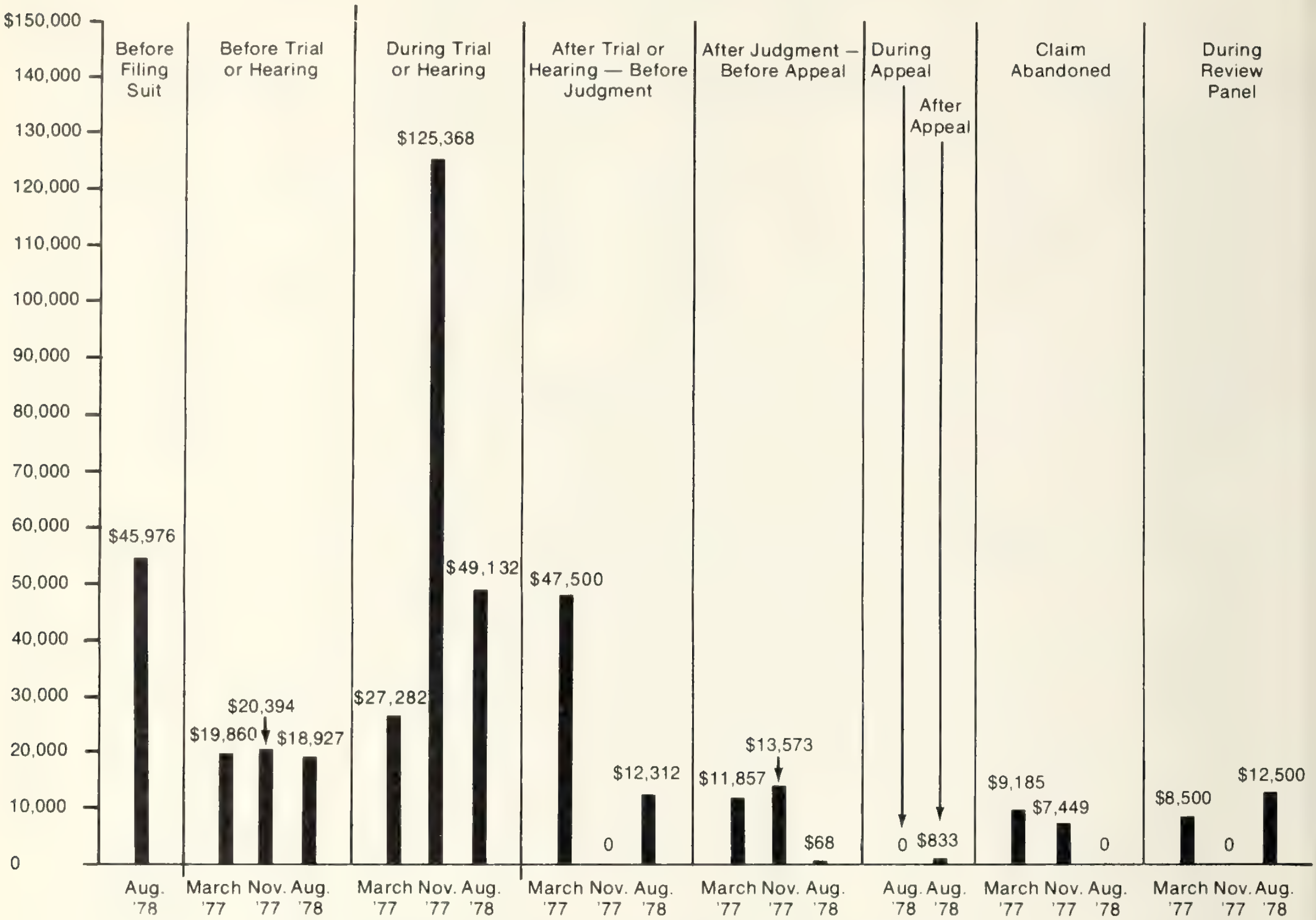
Type of settlement — the percentages



Total indemnity paid on all types of settlements



Average indemnity paid by type of settlement



Total Indemnity Paid by Insurers to Each Specialty
December, 1977 - August, 1978

Specialty	Number of Claims	Percentage of Claims	Percentage of Specialty to Total Doctor Pop.	Total Indem. Paid by Insurers to Specialty	Percentage of Total Payment
General surgery	50	13.0	8.9	$ 918,500	29.1
Obstetrics-gynecology	65	16.9	7.3	359,500	11.4
General practice — minor surgery	43	11.2	16.3*	508,050	16.1
General practice	16	4.1		128,438	4.1
Orthopedic surgery	31	8.0	2.9	239,000	7.6
Internal medicine	28	7.3	14.9	185,567	5.9
Anesthesiology	5	1.3	3.2	45,750	1.4
Otolaryngology	2	.5	1.5	3,000	.1
Urological surgery	8	2.1	1.9	32,250	1.0
Pediatrics	10	2.6	6.8	64,000	2.0
Neurological surgery	11	2.8	.7	4,602	.1
Psychiatry	3	.8	7.4	0	0
Thoracic surgery	8	2.1	.6	113,925	3.6
Ophthalmology	1	.3	3.3	0	0
Emergency medicine	8	2.1	1.3	112,500	3.6
Plastic surgery	6	1.6	.7	2,500	.1
All other	90	23.4	22.3	439,120	13.9
Total	385	100.1	100.0	$3,156,702	100.0

* *Includes general practice with and without minor surgery.*

In pharyngitis and tonsillitis

...prompt temporary relief of pain even before patients leave your office.

CĒPASTAT®
mouthwash/gargle/sore throat lozenges

Merrell

roven Anesthetic ffectiveness

praying the throat with CĒPASTAT ings soothing relief within minutes. ur patients will appreciate this relief ile waiting for therapeutic measures take hold. The well-established esthetic effects of CĒPASTAT prode soothing temporary anesthesia to irritated or inflamed oropharyngeal ucosa.

ĒPASTAT in your eatment room . . .

ed as a spray, CĒPASTAT is more ely to deliver the most relief to the inful area of the throat.

Suit the product to the patient . . .

The liquid is best for use at home as a spray or gargle. Lozenges are ideal for patients on the go.

A recommendation is best . . .

It costs less. Keeps the emphasis where you want it . . . on more important counter-measures — your prescription for anti-infectives, for example.

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215

83 (Y572A)

CĒPASTAT
mouthwash gargle
anesthetic antiseptic
CĒPASTAT
anesthetic antiseptic
CĒPASTAT
sore throat lozenges
anesthetic antiseptic cooling

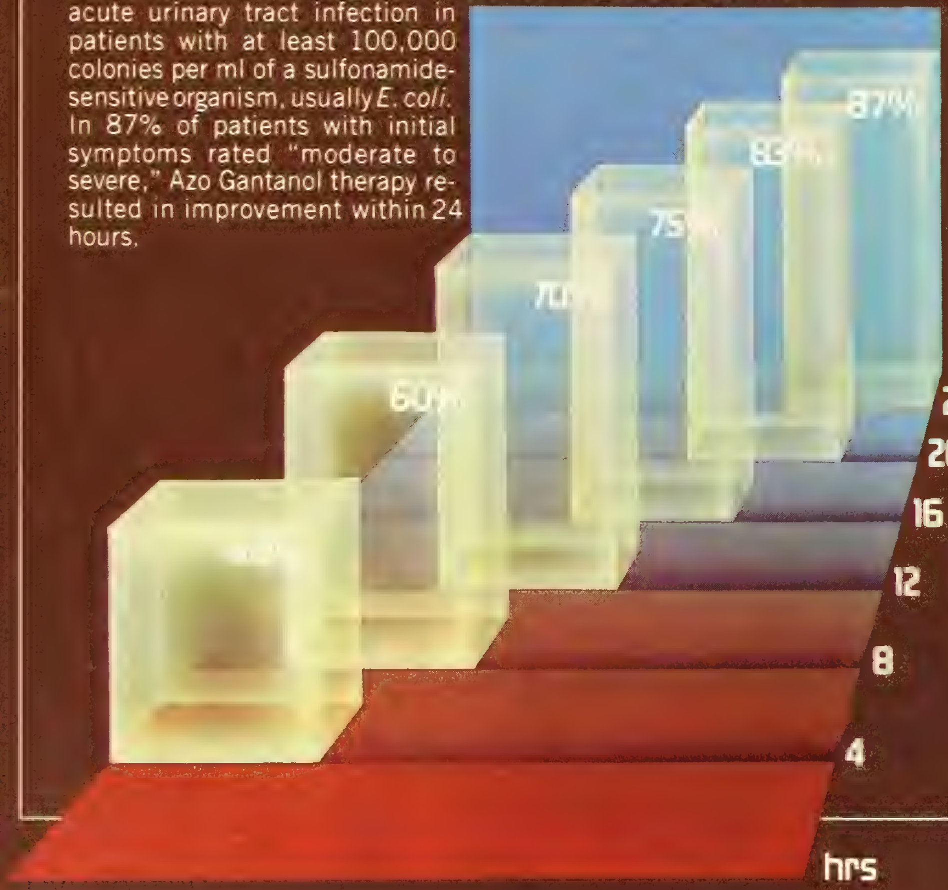
relief of minor sore throat when patients want it . . .

stat

Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for
the pain

for
the pathogens

Before prescribing, please consult complete
uct information, a summary of which follows
Indications: In adults, urinary tract infection
complicated by pain (primarily pyelonephriti
pyelitis and cystitis) due to susceptible orga
(usually *E. coli, Klebsiella-Aerobacter, Stap*
coccus aureus, Proteus mirabilis, and, less
quently, *Proteus vulgaris*) in the absence of
obstructive uropathy or foreign bodies. **Note**
fully coordinate *in vitro* sulfonamide sensiti
tests with bacteriologic and clinical response
aminobenzoic acid to follow-up culture medi
increasing frequency of resistant organisms
the usefulness of antibacterials including su
fonamides. Measure sulfonamide blood leve
variations may occur; 20 mg/100 ml should
maximum total level.
Contraindications: Children below age 12; su
fonamide hypersensitivity; pregnancy at term
during nursing period; because Azo Gantano
tains phenazopyridine hydrochloride it is co
dicated in glomerulonephritis, severe hepati
uremia, and pyelonephritis of pregnancy wit
disturbances.
Warnings: Safety during pregnancy not estab
Deaths from hypersensitivity reactions, agra
tosis, aplastic anemia and other blood dysc
have been reported and early clinical signs
throat, fever, pallor, purpura or jaundice) ma
dicate serious blood disorders. Frequent CB
urinalysis with microscopic examination are
ommended during sulfonamide therapy.
Precautions: Use cautiously in patients with
paired renal or hepatic function, severe alle
bronchial asthma; in glucose-6-phosphate
dehydrogenase-deficient individuals in who
dose-related hemolysis may occur. Maintain
adequate fluid intake to prevent crystalluria
stone formation.
Adverse Reactions: *Blood dyscrasias* (agran-
ulocytosis, aplastic anemia, thrombocytope
leukopenia, hemolytic anemia, purpura, hy
thrombinemia and methemoglobinemia); al
reactions (erythema multiforme, skin erupti
Stevens-Johnson syndrome, epidermal necr
urticaria, serum sickness, pruritus, exfoliati
dermatitis, anaphylactoid reactions, periorb
edema, conjunctival and scleral injection, p
sensitization, arthralgia and allergic myoca
G.I. reactions (nausea, emesis, abdominal p
hepatitis, diarrhea, anorexia, pancreatitis a
stomatitis); *CNS reactions* (headache, perip
neuritis, mental depression, convulsions, at
hallucinations, tinnitus, vertigo and insomn
miscellaneous reactions (drug fever, chills,
nephrosis with oliguria and anuria, periarter
nodosa and L. E. phenomenon). Due to cer
chemical similarities with some goitrogens,
uretics (acetazolamide, thiazides) and oral
glycemic agents, sulfonamides have caused
instances of goiter production, diuresis and
glycemia. Cross-sensitivity with these agent
exist.
Dosage: Azo Gantanol is intended for the ac
painful phase of urinary tract infections. *Us*
adult dosage: 2 Gm (4 tabs) initially, then
(2 tabs) B.I.D. for up to 3 days. If pain pers
causes other than infection should be soug
After relief of pain has been obtained, conti
treatment with Gantanol (sulfamethoxazole)
be considered.
NOTE: Patients should be told that the ora
dye (phenazopyridine HCl) will color the uri
Supplied: Tablets, red, film-coated, each co
ing 0.5 Gm sulfamethoxazole and 100 mg
phenazopyridine HCl—bottles of 100 and 5

ROCHE

Roche Laboratories
Division of Hoffmann-La Roc
Nutley, New Jersey 07110

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*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Zorka Basta, MD
2301 S. Parkway
Ann Arbor 48104

Steven C. Bauserman, MD
1840 Wealthy St., S.E.
Grand Rapids 49506

Howard A. Beadner, MD
4660 Haverhill
Detroit 48224

Steven C. Benz, MD
308 N. Broad St.
Adrian 49221

Richard A. Bereza, MD
2630 Maplewood, S.E.
Grand Rapids 49506

Gary A. Buffington, MD
1414 W. Fair Ave. #209
Marquette 49855

Timothy K. Dickinson, MD
551 Linn St.
Allegan 49010

Karen S. Dosi, MD
Harper Hospital
Detroit 48201

Ernesto S. Duterte, MD
G-3083 Flushing Rd.
Flint 48504

Frederic E. Eckhauser, MD
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Here are some hints for managing risk of medical practice

MSMS legal counsel suggests Michigan physicians pay close attention to the following article, in the interests of minimizing professional liability risk:

The following complaints surfaced most often in a recent survey of patients conducted by *Physician's Management* magazine:

1. Doctors are more interested in treating diseases than in trying to prevent them.

2. Doctors fail to keep appointment times.

3. Office staff members give patients little or no respect.

4. Doctors act like God. Questioning their decisions or asking for an explanation arouses their wrath.

5. Doctors and staff give no privacy in examining rooms.

6. Fees are not explained on statements.

7. Doctors abuse investigatory techniques — they use too many tests — and are too quick to prescribe drugs.

8. Waiting room facilities are inadequate.

9. Office hours are inadequate.

10. Medical problems are not fully explained.

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House majority floor leader 'keeps the engine running'

By Willah Weddon
***Special to* Michigan Medicine**

"I anticipate a wealth of legislation will be introduced early in the new 1979 legislative session to improve health services and the general health of the people," State Rep. Joseph Forbes, majority floor leader, predicts.

"Certainly there will be legislative proposals establishing standards and reimbursement for health care. I also expect bills addressing the insufficient number of physicians and allied health professionals in our state's medically underserved rural and center-city areas."

"It is likely, too, the recent Supreme Court decision limiting the Insurance Commissioner's regulatory responsibility for Blue Cross/Blue Shield of Michigan will prompt statute revisions and reorganization of the Blues," he continues.

Forbes expects there will be revisions of the health maintenance organization (HMO) statute introduced this session and a continued priority for implementation of key provisions in the revised Public Health Code. The latter will involve the hospital bed reduction plan which he feels holds promise to help contain health care costs.

Majority leader since 1975

"One major concern will be the availability of funds for such projects," he adds realistically.

Forbes was a self-made businessman prior to his election to the House in 1970 on the Democratic ticket. He began his 23-year career in public service as parent-teacher association president in Oak Park, subsequently serving as county supervisor, city councilman and mayor of Oak Park.

By 1975, "Joe" had earned a reputation for hard work, for being "as good as his word," and was chosen by his colleagues as majority floor leader. He has continued to hold the post, and his intense loyalty to House Speaker Bobby Crim (D-Davison) has made him an invaluable aide. Forbes has been described as the one who keeps the engine running in the House while Crim pours in the gasoline.

Ushers bills through House

Forbes' Generic Drug Act is considered a model law that other states are copying. He sponsored the "conflict of interest" measure, to regulate potential conflicts of interest on the part of public officials and the Forbes' Deceptive Trade Practices Act. He is also co-sponsor of proposed "sunset" legislation, which would require periodic review of all state agencies by the legislature to promote accountability and make the management of state bureaucracy more efficient.

During the past legislative session Forbes supported the Nursing Home Reform Bill (SB 659). It passed in the House as an amendment to the Public Health Code with overwhelming support on Sept. 28, and was sent back to the Senate for final action. There currently are 384 licensed nursing homes in Michigan which have a total of 40,693 beds, he pointed out. They are licensed and annually inspected by the Department of Public Health.

Rep. Forbes

"In 1977, the Department received and investigated 290 complaints about services provided in Michigan nursing homes," Forbes says. "The number of complaints has increased this year with 280 reported as of mid-September 1978." Under the reformed rules the Department would have additional flexibility in licensing mechanism and in standards enforcement as it also sets penalties.

Forbes has been a supporter of the Medical Treatment Decision Act (see page 44) which would permit a person to appoint an agent to accept or refuse medical treatment for him if the doctor determines the person is incapable of making that decision himself. In addition, it would allow a person to write an "advisory document" containing instructions for his care under similar circumstances. Purpose of the bill, drawn up by a citizens' task force containing many seniors, is to assure patient's wishes are followed as closely as possible whenever they are receiving medical treatment.

The following article is the eighth in a series. The articles, written especially for* Michigan Medicine *by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.

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MPMLC Clipsheet

Here are the details on applying for MPMLC coverage

Any physician who has completed the MPMLC professional liability insurance application might wonder at the great detail requested. While MPMLC is aware of the burden placed on the time of busy physicians by the application, there are important reasons behind its length — reasons which work to the benefit of all MPMLC member insureds. The detailed aplication accomplishes the following:

1. It minimizes the possibility of improper rating classification, ensuring that the physician is allowed any reduced premium for which s/he is eligible and reducing the chance of some physicians "subsidizing" others.
2. It allows the underwriting process to be completed, in most cases, without additional physician contact.

Recognizing the fact that uninterrupted liability coverage is vital to the physician, MPMLC makes every effort to process applications with speed. Each applicant can assist the company in providing this service by diligence in completing the application. Processing time for a thoroughly completed application is about two weeks. An incomplete application means that the underwriting staff must contact the physician for additional information. Trying to reach a busy physician by telephone or letter can cause a delay which may run into weeks or even months. Rather than submitting an incomplete application, applicants are encouraged to call the company for clarification of questions.

Physicians are advised to apply for coverage at least 30 days in advance of the required policy effective date. A policy may be issued with an effective date the same as or later than the date on which the application is received by MPMLC.

The Surplus Certificate Requirement

Delay can also be avoided by purchasing a MPMLC surplus certificate prior to or at the time of application. MPMLC is allowed to process applications only from physicians who own a surplus certificate or in whose behalf a surplus certificate has been purchased. This purchase helps to create the surplus necessary to meet certain Michigan Insurance Bureau regulations. Surplus certificates are currently available from MPMLC at $2,000 each.

If a certificate is not purchased at the time of application, company records are checked to determine if a prior purchase was made. When the surplus certificate purchased in behalf of the applicant is owned by another party (e.g. a professional corporation or physician employer), MPMLC must know either the surplus certificate number or the owner's name in order to match purchase records with the application for insurance. Failure to include this information will result in a delay which could easily be avoided.

The surplus certificate requirement for each insurance applicant may be met in one of several ways.

1. The insurance applicant may purchase a certificate in his/her own name.
2. The applicant's employer, professional corporation, or partnership may purchase it in the applicant's name.
3. The certificate may be purchased in the name of the employer, professional corporation, or partnership and designated, in writing, for use by the applicant.

MPMLC is concerned only that a particular numbered surplus certificate be linked with each applicant for insurance. In no case may a certificate be used by more than one physician at a time as a basis for insurance application.

When completing the subscription agreement (purchase form) for a surplus certificate, the purchaser is advised to consider that the certificate owner is the party in whose name the certificate is issued, regardless of who pays the purchase price. Serious consideration of this fact at the time of purchase may avoid a dispute over ownership rights at a later date.

(Continued on page 38)

This is the second in a series of articles intended to better inform Michigan doctors about the Michigan Physicians Mutual Liability Company and its activities. The application, prospectus, and subscription agreement mentioned in this article may be obtained by requesting a Participation Information Kit from MPMLC at P.O. Box 1471, East Lansing, MI 48823; phone 800-292-1460 (toll free) or 517-351-1150.

Mr. James W. Zwada, Marketing Vice President for the Michigan Physicians Mutual Liability Company, is available to assist physicians in applying for MPMLC coverage and to speak to groups wishing to learn more about the company.

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> *"This material is neither an offer to sell nor a solicitation of an offer to buy any of the securities of MPMLC. Such offering is made only by the prospectus. The securities of the company are offered for sale only in the State of Michigan to bona fide residents of Michigan and not for resale to non-residents of Michigan."*

Interest on Surplus Certificates

As stated in the prospectus, MPMLC does not anticipate paying interest on surplus certificates for several years. Any interest declared payable by the MPMLC board will be paid from earned surplus and must be approved by the Michigan Insurance Commissioner. When paid, interest may be as high as seven percent per annum and will be calculated for the calendar year (or part thereof) for which it is declared payable by the board.

Transfer and Redemption of Surplus Certificates

A MPMLC surplus certificate is transferable when there is no effective insurance policy linked with that surplus certificate. MPMLC is not allowed to match potential buyers and sellers, but may provide information on procedures to be followed in transferring certificates.

MPMLC surplus certificates are redeemable, subject to control by the Michigan Insurance Commissioner. Following are the circumstances in which the company is allowed to redeem surplus certificates:

1. When an applicant for insurance is denied coverage by the company. This does not apply to instances where coverage has been bound by MPMLC and subsequently cancelled by the insured.
2. When a physician who owns a surplus certificate dies.
3. When a holder of a surplus certificate moves from the State of Michigan and establishes domicile in a state or location other than Michigan.
4. When a holder of a surplus certificate retires from active practice.

The Michigan Insurance Commissioner has ruled that any redemption situation which will place total redemptions for any prior 12-month period in excess of $100,000 must be submitted to him for approval prior to the redemption. This may result in denial of a specific redemption request. Details on redemption procedures are available by contacting MPMLC.

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The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions.
However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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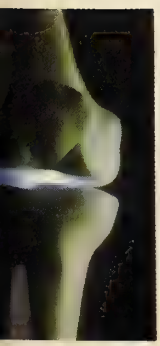

Motrin 400 mg TABLETS
ibuprofen, Upjohn

The confidence that comes from experience—
one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

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J-6857-4

The confidence that comes from experience—
one more reason to prescribe

Motrin 400 mg TABLETS
ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.
Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.
Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

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Category I courses

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Jan. 18-20, Rheumatology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Rheumatologists, internists, family physicians. **Cost:** $150. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 18 hours of Category I Credit.

Date: Jan. 22-27, Prospectives on Sudden Death. Location: Huntley Lodge — Big Sky, Montana. **Sponsor:** Henry Ford Hospital. **Co-Sponsor:** American Heart Association. **Cost:** AHA members: $175, non-members: $200. **Contact:** Office of Medical Education, Henry Ford Hospital, 313/876-1464. **Approved for:** 22 hours of Category I Credit.

Date: Jan. 24, Lymphoma Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Jan. 28-Feb. 2, Fourth Annual Seminar, "Emergencies in Medicine." Location: Boyne Highlands, Harbor Springs. **Sponsor:** Michigan Committee on Trauma, Michigan Society of Critical Care Medicine. **Cost:** $40. **Contact:** Robert F. Wilson, MD, or Theresa Sokol, WSU, Dept. of Surgery, School of Medicine, 540 East Canfield Ave., Detroit, 48201. **Approved for:** 23 hours of Category I Credit.

Date: Feb. 4-9, Family Practice Update. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: Feb. 5-9, Cardiology Tutorial Program. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital, Office of Continuing Education. **For:** General practitioners and internists. **Cost:** $300. **Contact:** Sidney Goldstein, MD, Div. of Cardiovascular Medicine, 313/876-2727. **Approved for:** 40 hours of Category I Credit.

Date: Feb. 10, Hematopathology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 15, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 19-23, Emergency Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians, internists, emergency physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 36½ hours of Category I Credit.

Date: Feb. 27-28, Topics in Psychosomatic and Behavioral Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, primary care physicians. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Feb. 28-March 1, Michigan Conference on Maternal and Perinatal Health. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Katie Brewbaker, MSMS, 517/337-1351. **Approved for:** 14 hours of Category I Credit.

Date: March 6-9, Hematology Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Hematologists. **Cost:** $225. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: March 14, Kidney Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: March 14-16, Advances in Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians. **Cost:** $180. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: March 21, Early Breast Cancer. Location: Kalamazoo Center Inn, Kalamazoo. **Sponsor:** Bronson and Borgess Hospitals Oncology Section. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All Interested Physicians. **Cost** $50. **Contact:** Leo Zelkowitz, MD, Bronson Hospital, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: March 22-23, General Surgery. Location: Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Surgeons. **Cost:** $140. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: March 24, A Day of Clinical Gastroenterology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Family physicians, internists. **Cost:** $70. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: April 2-27, Surgical Anatomical Review. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Surgeons. **Cost:** $425. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 120 hours of Category I Credit.

Date: April 12, Conference on Medical Aspects of Sports. Location: Towsley Center, Ann Arbor. **Sponsor:** MSMS. **Contact:** Mert Scholten, MSMS, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME. 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: April 16-June 18, Pediatric Seminar IV. Location: St. John Hospital Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $200. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 20 hours of Category I Credit.

Date: April 19, 20, 1979, Michigan Chapter American College of Surgeons. Location: Ann Arbor, Rackham Building. **Sponsor:** University of Michigan Medical Center. **For:** Surgeons. **Cost:** No charge. **Contact:** John H. McLaughlin, MD, 604 N. Woodward, Birmingham, Michigan. **Approved for:** 12 hours of Category I Credit.

Date: April 23-27, Cardiology Tutorial Program. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital, Office of Continuing Education. **For:** General practitioners and internists. **Cost:** $300. **Contact:** Sidney Goldstein, MD, Div. of Cardiovascular Medicine, 313/876-2727. **Approved for:** 40 hours of Category I Credit.

Date: April 24, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 8, Human Values and Health Care. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **Cost:** $50. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: May 10-11, Ophthalmology Conference. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

MSMS plays a part in Medical Treatment Decision bill

By Maryanne Butt
***Special to* Michigan Medicine**

Highly publicized moral, social and legal problems resulting from cases of patients who are unable to refuse or consent to further medical treatment have resulted in the drafting of Michigan House Bill 4778, often referred to as the "Medical Treatment Decision Act."

The bill is designed to permit conscious, competent adults to appoint an "agent" to make decisions, when necessary, regarding medical treatment.

The Medical Treatment Decision Act is to be considered by the state legislature in its next session. Rep. David Hollister-D, Lansing, sponsor of the bill, postponed consideration of the act at the last session because, he says, "it was apparent the bill would not pass both the House and the Senate before adjournment in mid-December."

Therefore, Rep. Hollister plans to reintroduce the bill, get an early hearing in the House next session, and get it through the Senate. He says he feels this delay is necessary and adds he is "confident that it will become law."

The drafting of the bill began when a "death and dying" task force was organized in the fall of 1976 by Rep. Hollister. The Michigan State Medical Society was among the organizations represented on the 35-member task force.

Several elements

The proposed Michigan legislation includes several elements. First, it tries to make clear that wishes regarding medical treatment expressed by a person while competent should be met when the person becomes incompetent. The bill also includes the penalty for anyone not following the patient's instructions. The rights of medical personnel to withdraw from a case when conscience cannot allow cooperation with the patient's wishes are provided. The bill makes it clear that deaths resulting from treatment refusal will never be construed as suicide or homicide. A minimum age for a person to appoint an agent is included in the bill.

According to Dan English, MD, task force member and chairman of the Department of Surgery in MSU's College of Human Medicine, the passage of the Medical Treatment Decision Act is necessary to replace the present "erratic Code Blue system which many doctors are uncomfortable with and which puts nurses in the middle."

He feels the bill is necessary from a moral point of view, saying that the present system is a form of "medical roulette," with too much chance involved. He concedes many persons will never appoint an agent because this is a "death-denying society." He says since appointing an agent will be voluntary, not mandatory, for those people who do care that their wishes will always be heeded and who don't accept the present system, this bill will provide them the protection they deserve.

Doctor English adds that because only 20-25 percent of the population in this county today has a family physician who knows patients personally and understands their values and life styles, this bill has become a necessity.

An important part of the bill eliminates the agent system in an emergency situation. According to Doctor English, such a critical moral and medical decision would not be practical in the emergency room — even if the attending medical personnel were aware of the existence of an agent.

Opposition exists

The Medical Treatment Decision Act has its opponents. The Right-to-Life organization is vehemently fighting its passage, and there is a strong Catholic contingent in the state against the bill. Opponents include medical personnel as well, who base their opposition on moral, ethical or legal aspects of the bill.

Dan O'Bryan, MD, an oncologist at Henry Ford Hospital in Detroit, says although he supports the decision-making concept of the bill, he doubts it will make much difference in his practice. He says his patients, for the most part, accept death peacefully and the stopping of treatment is most often agreed upon by the family.

He also expresses a concern as to whether the bill will promulgate more legal red-tape type forms. "In the cancer field, this bill could complicate what is relatively a straightforward issue."

D. Bonta Hiscoe, MD, of Lansing, also feels that, if the bill is passed, not much will change. "Most of the time," he says, "we'll do just as always." He believes that agents will not be used that often and, when they are, it will be because the patient has no family. He feels that many physicians will be leery of accepting the agent's word, until such time the bill has proved its ability to stand up in the courts.

Although Doctor Hiscoe has these reservations, he supports the bill's passage. "If the concept of the bill is accepted and the (legal) kinks are worked out, it will help to save the patient's dignity and could solve the problems of decision-making by relieving the doctor of the final decision, providing safer grounds on which to stand."

Official MSMS view

At its May, 1978, meeting, the MSMS House of Delegates, in regards to the "Death with Dignity Law" (at the time, the bill had not yet been formally drafted), resolved:

> "That the Michigan State Medical Society support legislation which will allow an attending physician to participate with the patient and/or the legally appointed agent in deciding the continuation of medical treatment when faced with terminal illness."

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Michigan Eye Bank needs MDs' help for success of enucleation program

By Betty L. Herring
Special to **Michigan Medicine**

Certified enucleators are helping to remove the burden of that immediate post mortem procedure from physicians and ophthalmologists . . . but the support of the Michigan medical profession still is vital to the continued success of the Michigan Eye-Bank in providing eye tissue for keratoplasty and other surgical procedures, according to John W. Cowden, M.D., medical director of the Wayne State University Division of the Michigan Eye-Bank (MEB).

Adoption on December 17, 1974 of Michigan House Bill No. 4468 authorized the training and certification of non-physicians to enucleate donated eyes. The bill, amending the "Uniform Anatomical Gift Act," carried two major provisions:

(1) Certification must be received before an individual, other than a physician or surgeon, may perform the operation to excise the eye, or any part of the eye, and

(2) That certification may be granted by a state medical school after successful completion of a comprehensive eye enucleation course meeting the criteria of that school.

From the inception of the Michigan Eye-Bank program in 1957 to implementation of the enucleator training program in 1975, the eye-bank was entirely dependent upon the generosity of the physicians, surgeons and ophthalmologists who gave their skills. But supporters of the eye-bank program realized that placing even the most willing of them on 24-hour call created unrealistic demands upon the time and energies of professionals who feel deep responsibilities to their own patients.

The 1974 law cleared the way for a logical and successful solution to the problem, making it possible for Wayne State University to offer the first such course available in Michigan.

Among those who trained with the first group was Gordon W. Rose, PhD, associate professor and associate director of the WSU Department of Mortuary Science. It was through his efforts that on May 30, 1975, the WSU Division of the MEB, in cooperation with the university's Department of Mortuary Science, presented the course to its class of 53 graduating students.

It was so well-received that the decision was made to include the course as a regular part of the mortuary science curriculum. The MEB was the first eye-bank in the nation to accomplish this, Doctor Cowden said.

At the present time, about 200 certified enucleators, located throughout the state, form a principal link in the chain of organization that has hoisted the MEB to the position of seventh largest in the nation. That ranking, according to the Eye-Bank Association of America, is based upon the number of eyes received and the number of surgical procedures performed annually among the 77 eye-banks located throughout the U.S.

The cooperation of the physician or surgeon is indispensible, even though he is called upon less often to give his time for the actual enucleation procedure, Doctor Cowden said.

The family physician or attending specialist is in the best position to instill in the minds of the potential donor or his family, the idea of eye or organ donation.

Doctor Cowden and Roger F. Meyer, MD, medical director of the University of Michigan Division of the MEB, understand the position of many doctors who are reluctant to broach the subject of tissue donation. But evidence indicates increasing numbers of Americans are willing that their eyes and those of their family members be used, after death, so others may see. Many just do not know how to go about donating eyes or organs, or, in the trauma surrounding the death of a loved one, they simply forget.

"The desire and intent to help others lies within nearly everyone," Doctor Cowden observed. "Usually, it is up to a few of us to stimulate that intent into action."

A question, such as, "Did the patient express a wish to be an eye or organ donor?" or the suggestion that such a gift might be considered, often is all that is needed to obtain the signature of the legal next-of-kin on a release form authorizing enucleation of the eyes for use by the MEB.

Immediate action is imperative because, for the eyes to be surgically useful, they must be enucleated within a maximum of four to six hours after death, Doctor Cowden said.

Many potential eye donors are overlooked at the time of their death. Although the MEB has many thousands of eye-pledge cards on file and the person may carry a pledge card in his wallet, hospital personnel normally would not go through his effects. Unless someone speaks up, or the question is asked, there is no way of knowing the patient's wishes.

"Publicity and education of the general public are extremely important," Mrs. Debra L. Wagenman, former executive director of the WSU Division of the MEB, commented. "However, it is most critical the physician remind the family that it was the patient's intent to be a donor, even though he may carry a pledge card," she said.

"We couldn't operate the eye-bank without the cooperation of the doctors and the hospitals," Miss Patricia J. Krause, executive director of the University of Michigan Division of the MEB, agreed.

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News

By Katie Brewbaker, MSMS staff

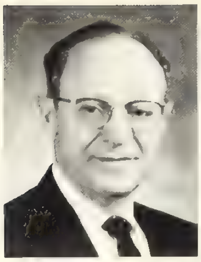
The "Sherlock Holmes of Medicine" might be an apt description of **Lawrence Simson, MD,** forensic pathologist at Lansing's Sparrow Hospital. One of only five forensic pathologists in Michigan, Doctor Simson was the subject of an article in the *Lansing State Journal* explaining the mysteries of this little known medical specialty.

John A. Gronvall, MD, dean of the U-M Medical School is the new chairman of the Association of American Medical Colleges (AAMC). The AAMC, established in 1876, represents 124 U.S. medical schools, 50 academic societies, 400 teaching hospitals, and medical students.

Sherwood B. Winslow, MD, Battle Creek, has been named president-elect of the Frederick A. Coller Surgical Society. The Society was founded in 1948 to honor Doctor Coller who served as director of the U-M department of surgery for many years.

Munson Medical Center is the site for a series of monthly informational lectures to educate the general public on common ailments, diseases, and other problems of modern living, sponsored by the Munson Development Council and the Tri-County Medical Society. **Thomas Auer, MD,** Traverse City, discussed stomach pains, and ulcer prevention, at the November meeting. In December the speaker will be **Charles R. Haberlein, MD,** also of Traverse City, who has chosen the menopause as his topic.

The new president of the International College of Surgeons, US Section, is **Meyer O. Cantor, MD,** chief of surgery at North Detroit General Hospital. Doctor Cantor is an author of numerous medical books and inventor of a special intestinal decompression tube.


Doctor Cantor

Doctor Gronvall

Doctor Lewis

Doctor Mariona

Ishpeming physician **R. B. Williams, MD,** has established a scholarship program for pre-medical students at Northern Michigan University. The scholarship, providing $1,000 per year for up to two years, will be awarded to a junior or senior student with a minimum overall 3.0 grade average.

The U-M Regents have announced the appointment of **Paul R. Lichter, MD,** as new chairman of the U-M department of ophthalmology. Doctor Lichter succeeds **John W. Henderson, MD,** who is retiring after serving 10 years as chairman.

The new chief of Hutzel Hospital's section of transplant and vascular surgery is **Michael P. Kaplan, MD.** Doctor Kaplan previously served as director of transplantation and associate professor of surgery at the College of Medicine and Dentistry of New Jersey-Rutgers Medical School and its Raritan Valley Hospital.

Elected to the Michigan Senate is **Edward Pierce, MD,** of Ann Arbor, representing the 18th District. Doctor Pierce is the first physician in recent years to be elected to this legislative body.

MSMS Immediate Past President **Vernon V. Bass, MD,** is recipient of the Michigan Association of the Professions' Outstanding Service Award. **George W. Slagle, MD,** Battle Creek, received the MAP Past Presidents Award.

If the *Grand Rapids Press* reflects the attitudes of the community, physicians in the Kent County area are held in very high esteem. **J. Duane Miller, MD,** has been spotlighted by the *Press* in its "With Us Today" column which pays tribute to citizens who have made outstanding contributions to society. Doctor Miller was recognized for both his professional and civic accomplishments. Several other Grand Rapids physicians have been chosen for this signal honor during the past year, as noted previously in *Michigan Medicine* News.

Oct. 20 was "Doctor **Leonard C. Blakey** Day" in Monroe, and what more fitting and rewarding gift could people give their "doc" and friend on his 80th birthday. Reminiscing on the "good old days" at his birthday celebration at Memorial-Mercy Hospital, Doctor Blakey recalled when house calls were $3 (when and if you could collect) and it cost the astronomical fee of $25 for an OB home delivery. Which wasn't bad during The Depression.

The first woman president of the Genesee County Medical Society, **Vivian M. Lewis, MD,** has this advice for patients, colleagues, and herself: "Relax and enjoy!" Daughter of an Oklahoma family physician, pediatrician Lewis maintains a busy practice with her surgeon husband, **Billie Lewis, MD,** but still finds time to give generously to the community and her profession. The Lewises' three children seem destined for medical careers as well. Vivian, the oldest, is a sophomore at Wisconsin University School of Medicine. William, a freshman at Morehouse, and Beverly, a Flint Central Honor Student, also are planning medical careers.

Federico G. Mariona, MD, WSU associate professor of obstetrics and gynecology has been elected to the board of directors of the International Association of Material and Neonatal Health. Doctor Mariona also has been chosen president of the Perinatal Association of Michigan and selected to help establish a Perinatal Center at Hutzel Hospital, funded by a grant from the National Foundation-March of Dimes. In addition to these responsibilities, Doctor Mariona will travel to Argentina, at the invitation of its medical community, to conduct a seminar on maternal fetal medicine.

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AUTOPSY

By J. H. Ahronheim, MD
Jackson

Death is your field, they say, the topic of your aims,
the subject of your search and exploration.
How wrong they are, these simple souls. Not death it is,
but life I study; life alone, if tainted by disease.

The body's structures I explore, and touch with
searching hands,
the muscles, bones, the veins and nerves,
the tendons and the ligaments as well.

I hold the heart; emotions it betrays,
it makes us blush and blanch with spontaneity,
it pounds with fear and hopeful expectations.
It carries blood through miles of channel ways,
to feed, protect, coordinate, control.
It beats with never tiring pulse, stilled only at the end.

Life-giving oxygen is captured by the lungs,
and carried through the blood stream to uncounted cells.

The long digestive tract provides the food
for sustenance and for the children's growth.

The procreative system is designed
to keep the human race alive.
Its organs hold the cells of never ending life
and genes which make us what we are
and carry traits to progeny.

And, finally, the brain, so awesome in design,
barely explored and full of mystery.
The source of all emotions, good and bad,
of art and science and, alas, of wickedness as well.
Fountain of love and hate, of joys and moods,
it has control of ev'ry body's act.
It makes us move and hear and speak,
it makes us weep and love and feel,
it makes us sleep and makes us wake,
it heals the wounds and mends the bones.
Unlike the beast, it makes us think.
What it creates we surely know, but how it does,
no human being has conceived up to this day.

This thing called "Autopsy" explores not death,
but opens up the mysteries of life,
detects disease and crime, proves innocence and guilt,
promotes man's scientific and exploring aims,
brings truth to light, dispelling superstition.

It's not all good which is disclosed to me.
I see the tragic side-by-side with purposeful events.
I see reaction to infective germs
and the attempt to vanquish the invading foe.
I see malignant growths and body's desp'rate try
to overcome the evil cells, dividing uncontrolled.
I see disease, its cause unrecognized as yet,
disrupting body functions oft beyond relief.

I sense frustration paired with confidence
that science will, some day, reveal to us
the mysteries which still escape the searching mind.

Life I explore, and I stand in awe before the Lord.

Doctor Ahronheim is Jackson County Medical Examiner

Tenuate® ©IV
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result)
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633
Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A

Licensor of Merrell®

References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M. A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

8-3921 (Y587A)

Whether overweight is a complicating factor... or just uncomplicated overweight.

Tenuate® Dospan® ⓒIV

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

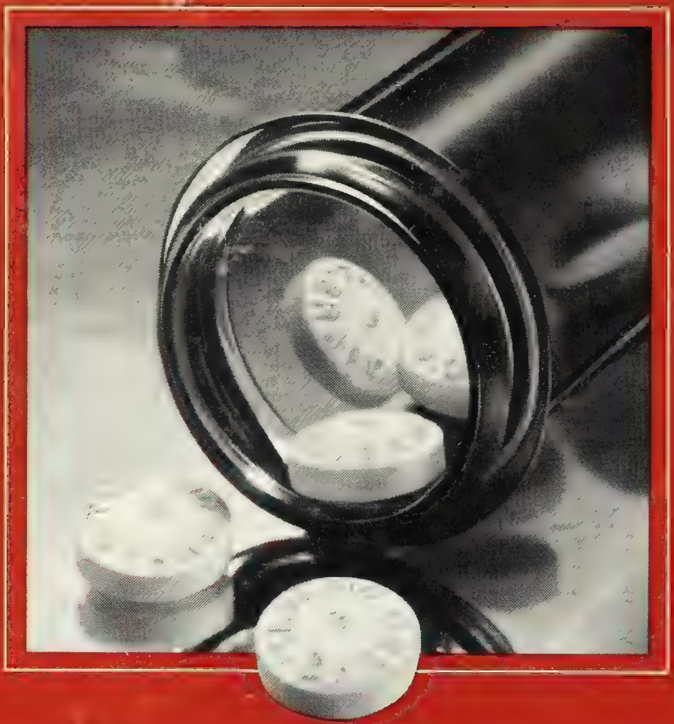
Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "... anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense.
And it's responsible medicine.

Merrell

For prescribing information see opposite page.



EMPIRIN® COMPOUND
c̄ CODEINE

Each tablet contains: aspirin, 227 mg; phenacetin, 162 mg; and caffeine, 32 mg; plus codeine phosphate in one of the following strengths: #**4**—60 mg (gr 1); #**3**—30 mg (gr ½); #**2**—15 mg (gr ¼); and #**1**—7.5 mg (gr ⅛). (Warning—may be habit-forming). CIII

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. . . *"BCBSM will be bringing to attention of Wayne and Oakland . . . societies information on physicians who have . . . high levels of . . . tests."*

My congratulations to *Michigan Medicine* for the article appearing on Page 551 of the October 1978 issue of *Michigan Medicine.*

I, too, was heartened by the deliberations of the Oakland County Medical Society Ethics Committee and the guidelines that they developed on the issue of "kickbacks." Unfortunately, it is highly unlikely that either a physician so involved or a laboratory so involved is going to admit to receiving or giving "kickbacks."

The article also indicates the Oakland County Medical Society support of the MSMS House of Delegates Resolution of 1978 which requests component medical societies to investigate laboratory ownership arrangements within their boundaries — and to take immediate action to assure that their physician members are not associated with any laboratory ownership schemes which exploit the patient. I would suggest that it would be a stronger action for the component medical societies (or the MSMS House of Delegates) to ask the Judicial Commission to review its decision that physician ownership of laboratories and/or diagnostic facilities is not unethical — unless the distribution of profits is based on the level of referrals. It was my pleading before that Judicial Commission meeting that even though profits were distributed on the basis of the amount of investment — physician ownership with such facilities was a strong inducement to make sufficient referrals to assure the profitability of the facility.

You will be pleased to know that the Wayne County Medical Society is also beginning consideration of the ethics of relationships between physicians and clinical diagnostic laboratories with particular emphasis on the economic exploitation of the patient and/or his third party payor possible in such arrangements.

In the near future, Blue Cross and Blue Shield of Michigan will be bringing to the attention of the Wayne and Oakland County Medical Societies information on physicians who have unusually high levels of prescribing or diagnostic tests.

Louis F. Hayes, MD, Vice President
Professional Affairs
Blue Cross/Blue Shield of Michigan

"All of us in Michigan . . . will miss (Tony Doherty)."

The passing of Tony Doherty, executive vice president of the Michigan Health Council, on Nov. 17 was a shock to me and to the members of the Department of Family Practice at Michigan State University. Tony was a strong friend of our department, and of the family practice movement in Michigan.

The last meeting which Tony attended was here at the Department of Family Practice on the morning of Monday, Nov. 13. He came to participate in a discussion of wholistic health care, as described by a delegation from Hinsdale, Illinois. He did not look well at the meeting, and left to go home. He had a cardiac arrest when he went to an emergency room later that day, and had a fatal stroke on Friday.

For 21 years Tony Doherty worked for the Michigan Health Council, promoting its placement service for physicians and dentists. He helped to bring new medical manpower to numerous small towns throughout the state. Doherty was a consistent advocate of the expansion of family practice education, both in medical schools and in residencies, because of the tremendous demand for family physicians in rural areas. Recently, Doherty spoke up for the need for training more psychiatric attending nurses in Michigan, and for establishing a State Health Service Corps.

Tony Doherty left unfinished a monograph on the role of Irish Americans in health policy planning. He was himself the grandson of an Irish immigrant. All of us in Michigan, and Irishmen everywhere, will miss him.

Roy J. Gerard, MD
Professor and Chairman
MSU Dept. of Family Practice

Continuing the presentation of MSMS citations to hospitals which have participated several years in the American Medical Students Association Medical Education Community Orientation project is MSMS Councilor Leland E. Holly II, MD, Muskegon, left. At right is Frank Crisben, president, Hackley Hospital, Muskegon.

In memoriam: 'Tony' Doherty

By Brooker L. Masters, MD
Baldwin

There is a great emptiness in Michigan's health care family with Tony gone.

Born John A. Doherty, he was instantly "Tony" to the many thousands he met, both in a personal and business way. His infectious smile and ingratiating personality were visible manifestations of an inner conviction that the world was good and could be made better by anyone who truly cared for his fellow man.

There are many who think that the Michigan Health Council *was* Tony Doherty. Indeed, for 20 years his every breath was consumed by a sincere desire to promote the cooperation of all the varied segments of the health care team in Michigan. The stated function of the Michigan Health Council was Tony's reason for being. He was exceedingly effective in promoting public relations for the entire health care profession: in the legislature, with organized labor, in the medical schools, in industry, and in many of our allied professions.

Tony initiated many fine projects, seeking out interested people to plan and support needed activities. Such work always required long hours and endless meetings, but his sincerity and friendliness invariably opened the doors which provided the organizational and financial support for the many worthwhile projects such as Michigan's Physician Placement Service.

Indicative of the esteem in which he was held was the award by the Michigan Academy of Family Physicians. In 1977, in recognition of his untiring efforts to attract family physicians in communities throughout Michigan, the MAFP awarded him a place on their Honor Roll of Distinguished Achievement.

In many ways, the Michigan Health Council will be a permanent memorial to Tony. He truly believed that the cooperation of all the elements in Michigan's economy could result in improved health and services for all the people. He labored mightily towards that goal.

There is no question but that we are all stronger because of his efforts. Tony would wish no greater tribute than the knowledge that others will follow in his footsteps to promote better health for all the citizens of Michigan.

John A. Doherty
1918-1978

John A. Doherty, 60, long-time executive vice president of the Michigan Health Council, died Nov. 17. Mr. Doherty, of East Lansing, was head of the nonprofit, educational organization for more than 20 years. The Health Council, located at Michigan State University's Nisbet Building, is made up of state-level agencies interested in health matters, and was founded by MSMS in 1943.

Mr. Doherty was a founder and executive board member of the American Council on Health Manpower, served on the Governor's Task Force on Aging, and was a member of a state Advisory Council on Health Education. He was named man of the year in 1972 by the National Health Council and American Hospital Association and received recognition from the Detroit Medical/Dental Center in 1973.

Doctor Masters is past president of the Michigan Health Council and MSMS, and is a member of the Michigan delegation to the AMA.

Interested physicians may make memorial contributions to the John A. Doherty Scholarship Fund of the Michigan Health Council, Stephen Nisbet Building, 1407 S. Harrison Road, East Lansing, 48823.

(Advertisement)

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McCullagh Leasing, Inc. is offering an exclusive lease plan to members of Michigan State Medical Society at the same low rate as a large fleet user.

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All leases are for a maximum of 30,000 miles. Any mileage accrued in excess of 30,000 miles will be charged at the rate of three cents per mile.

Delivery is included, FOB Detroit, and will be performed by a McCullagh Leasing contract driver, at your convenience, directly to your front door. The car will be properly licensed, serviced, and washed. There is no need for you to consume valuable time on this matter. Thirty-six month rates available on request.

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The prices quoted will be for members only, but cars may be driven by personnel authorized by the lessee when insurance is provided by the member.

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Coupe	287.00
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Coupe	360.00
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Cadillac Seville	
Sedan	387.00
Total Payments	9288.00

Price includes: Standard equipment, AM/FM stereo radio, tinted glass, air conditioning, white sidewall tires, power seats – six way, vinyl roof, power door locks, power trunk release, door edge guards, cruise control, tilt steering wheel.

Lincoln Continental	
Coupe	291.00
Total Payments	6984.00
Sedan	298.00
Total Payments	7152.00
Lincoln Mark V	
Coupe	302.00
Total Payments	7248.00

Price includes: Standard equipment, AM/FM stereo radio, tinted glass, vinyl roof, tilt steering wheel, rear window defroster, cruise control, interval wiper system, leather interior trim, power seats, twin comfort seats, power antenna, wire wheel covers, (opera windows on four door sedan).

All prices include tax & license

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Sedan	226.00
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Sedan	217.00
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Pontiac Bonneville Brougham	
Sedan	216.00
Total Payments	5184.00

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All prices include license & tax

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Chevrolet Monte Carlo "S"	
Coupe (V6)	151.00
Total Payments	3624.00
Oldsmobile Cutlass Supreme	
Coupe (V6)	157.00
Total Payments	3768.00
Mercury Cougar XR-7	
Coupe (V8)	175.00
Total Payments	4200.00
Ford Thunderbird	
Coupe (V8)	150.00
Total Payments	3600.00

Price includes: Standard equipment, automatic transmission, power steering, power disc brakes, AM radio, tinted glass, air conditioning, white sidewall tires, body side molding, wheel covers, (power windows and power door locks on Cougar).

All prices include tax & license

Deaths

Ralph V. August, MD
Muskegon Heights

Ralph V. August, MD, former Muskegon Heights obstetrician and gynecologist, died Oct. 25 at the age of 69. Doctor August was a graduate of the University of Michigan Medical School. He was one of the first doctors in the country to offer obstetric patients hypnosis as an alternative anesthetic. He was also the team doctor at Muskegon Heights High School. Doctor August's memberships included American College of Obstetricians and Gynecologists, International College of Surgeons, American Society of Clinical Hypnosis, International Society for Study of Fertility, American Society for the Study of Sterility and International Society for the Clinical and Experimental Hypnosis. He also held memberships in the American Society for Clinical and Experimental Hypnosis, American Committee on Maternal Health, American Association for Advancement of Science, and the New York Academy of Sciences.

Lewis Green, MD
Livonia

Lewis Green, MD, Livonia general practitioner, died Nov. 8 at the age of 73. A graduate of the University of Michigan School of Medicine, Doctor Green was on the staffs of Crittendon, Mt. Carmel and Sinai hospitals. He was an alternate delegate with the Wayne County Medical Society. He was a former examiner for the Detroit Health Department, Communicable Diseases, and a former instructor on communicable diseases at St. Mary's Hospital, Detroit.

Earl E. Hamilton, MD
Traverse City

Earl E. Hamilton, MD, Traverse City, died Nov. 18 at age 71. A general practitioner, Doctor Hamilton graduated from the Vanderbilt University School of Medicine, Nashville, Tenn. During World War II, he served as a flight surgeon with the U.S. Army Air Corps. He was a past president of the Grand Traverse County Medical Society, and was a member of the Michigan Academy of General Practitioners.

William D. Hayford, MD
East Lansing

William D. Hayford, MD, 61, East Lansing, died Nov. 14. A University of Minnesota graduate, Doctor Hayford was a specialist in internal medicine. He was affiliated with Sparrow and St. Lawrence hospitals, Lansing. He was a member of the Michigan Society of Internal Medicine and served during World War II as a medical officer.

Maurice P. Meyers, MD
Southfield

Maurice P. Meyers, MD, Southfield, died Nov. 20 at the age of 76. Doctor Meyers was a graduate of Rush Medical School, University of Chicago. He was a surgical consultant for the Veterans Hospital in Allen Park and also was affiliated with Harper, Sinai and Crittenton hospitals, Detroit. He was a member of the American College of Surgeons, the Detroit Surgical Society and the American Proctologic Society.

O. William Pickard, MD
Detroit

O. William Pickard, MD, 86, Detroit, died Nov. 8. A former chief of obstetrics and gynecology at Grace Hospital, Doctor Pickard graduated from the University of Michigan Medical School. He was a past president of the Michigan Obstetrics and Gynecological Association and the Detroit College of Surgeons. He was a founding fellow of the American College of Obstetrics and Gynecology.

Linwood W. Snow, MD
Northville

Linwood W. Snow, MD, 82, Northville, died Nov. 19. An ophthalmologist, Doctor Snow graduated from the University of Michigan Medical School. He was a past president of the Homeopathic Medical Society and a former team physician for the Northville school athletic program.

Fred L. Strickroot, MD
Detroit

Fred L. Strickroot, MD, Detroit, died Oct. 27 at the age of 66. Doctor Strickroot was a graduate of the Wayne State University School of Medcine, specializing in internal medicine. He was chief of medicine and chief of staff at St. Joseph Hospital. He was a member of the American Heart Association.

George C. Thosteson, MD
Bloomfield Hills

George C. Thosteson, MD, Bloomfield Hills, died Nov. 10 at the age of 72. A specialist in internal medicine, Doctor Thosteson was a graduate of Wayne State University College of Medicine. The nationally syndicated columnist was a founding member of the American Diabetes Association and a past president of the Michigan Diabetes Association. He was a fellow in the American College of Physicians, a member of the Detroit Academy of Medicine and the American Association of Science Writers. He also was a diplomate of the American Board of Internal Medicine.

Gerald A. Zick, MD
East Lansing

Gerald A. Zick, MD, 52, East Lansing, died Nov. 11. A pediatrician, Doctor Zick graduated from the University of Michigan Medical School. A new five-bed unit for critically ill children was recently dedicated at Ingham Medical Center, Lansing, in his honor. Doctor Zick was a member of the Western Michigan Pediatric Society and a fellow of the American Academy of Pediatrics.

Carl R. Zollicker, MD
Grosse Pointe

Carl R. Zollicker, MD, Grosse Pointe, died Nov. 2 at the age of 89. Doctor Zollicker graduated from the Wayne State University School of Medicine and was affiliated with Deaconess Hospital. A general surgeon, he was past president and secretary of Lapeer County Medical Society.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When
impotence
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Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

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Write for new double-blind study reprints and samples.

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MEDICAL DIRECTOR — licensed physician, full or part time, ideal for retired or semi-retired physician looking to slow down. Ideal for physician who has completed his or her residency and needs a good start. Do physical exams in assessing donor suitability for a plasma-pheresis. Call or send curriculum to: Doug Ulynstra, American Plasma Mgt., Inc., 2827 E. Grand River Ave., East Lansing, MI 48823. Phone 517/351-2620.

SAN FRANCISCO BAY AREA — MIDWEST cardiologist. An exciting opportunity in Clinical Research Phases I, II, & III with new cardiovascular agents is offered by Ethical Pharmaceutical Companies in the San Francisco Bay Area and Midwest. Excellent salaries, bonus and personal benefits offered. For complete information write or telephone collect A. W. Blendow, 185 Front Street #205, Danville, California 94526. Telephone 415/837-8115.

THREE YEAR APPROVED Psychiatric Residency Program now appointing for an immediate unexpected opening and for July, 1979. Small intensive psychiatric hospital, JCAH approved, affiliated with University of Iowa Medical College. Comprehensive program including two adult psychiatric units, adolescent unit, children's unit, alcohol and drug abuse unit, with innovative community liaison, and OPD. Eclectic approach. Situated in picturesque northeast Iowa near large cities with cultural advantages, but in rural setting. Ideal for family living. No financial sacrifice while learning. Top salary: first year $23,478, second year $24,648, third year $25,896; liberal fringe benefits; some housing available. Opportunity to join staff upon completion of training. All applicants must have completed one year in an American approved training program in internal medicine, family practice, or pediatrics or a flexible one year program, including four months in internal medicine. Write or call J. T. May, MD, Superintendent, or B. J. Dave, MD, Director of Education, Mental Health Institute, Independence, Iowa 50644.

OPHTHALMOLOGIST: Full or part time. Would prefer a sub-specialist or a general ophthalmologist with no interest in cataract surgery. Reply MSMS, 120 W. Saginaw, Box 1, East Lansing 48823.

ASSOCIATE NEEDED for immediate equal partnership — family physician, internist, or pediatrician to join a Board Certified family physician; substantial salary, fees for services, health insurance, and malpractice; new modern office building with privileges in three major hospitals available; in beautiful suburb within 8 miles of Grand Rapids; excellent education, recreation, schools and economy for family living. Call Michigan 616/457-2450.

STAFF PHYSICIANS, East Lansing, Ingham County. Michigan State University student health service is currently recruiting for full-time staff physicians. The University has a student enrollment in excess of 40,000 and is located in a metropolitan area of 250,000. Athletic and cultural programs are available to staff. Olin Health Center is located on campus and provides facilities for students in need of medical, surgical or psychiatric care. Facilities include a large outpatient program, in addition to a separate outpatient gynecological clinic, limited inpatient capability and completely outfitted private office suites. Physicians must be licensed to practice in Michigan or immediately capable of obtaining such a license. Professional work is in the area of general practice with surgery confined to limits of the physician's experience. No pediatric, geriatric or obstetrical service. Physicians rotate night and weekend duty. Fringe benefits include TIAA CREF retirement program, paid hospital and malpractice insurance, one month paid vacation and liberal sick leave benefits. Starting salary negotiable. Contact Dr. Lawrence Jarrett, Acting Medical Director, Olin Health Center, Michigan State University, East Lansing, Michigan 48824. MSU E.O.E.

WANTED: INDUSTRIAL PHYSICIAN full or part time, large industrial corporation, salary competitive, malpractice insurance, excellent employee benefits, including life insurance, hospitalization, major medical insurance, accident-sickness insurance, long-term disability, dental insurance, liberal vacation and retirement programs, stock investment plan, CME time. Send curriculum vitae and references to P.O. Box 29834, Detroit, MI 48229.

MICHIGAN, JACKSON; within commuting distance of Ann Arbor, Lansing. Full-time career oriented emergency physicians. Full specialty backup, 40,000 visits per year. Fee for service divided among group according to hours worked. Excellent fringes; pension; profit sharing; paid malpractice. Minimum two years post-grad experience EM or related field. Apply to Jackson County Emergency Service, P.O. Box 1091, Jackson, MI 49204.

POSITIONS AVAILABLE — With offices in Lansing, Oak Park and Traverse City, there are openings for physicians board certified or qualified as internists, family physicians or psychiatrists working with the Disability Determination Service under the Social Security Administration. Salary currently between forty-seven and fifty-eight thousand per year, plus 23% fringe benefits, including life, accident, long term disability, dental, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years service. Liability insurance not necessary. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7830. In Michigan, call toll free 1-800-292-2710.

OCCUPATIONAL PHYSICIAN — For large multi-specialty group in beautiful Milwaukee, WI area — new facility of long established clinic. Office space and all equipment supplied by group. Pre-employment exams, diagnostic evaluations, on-the-job injuries for more than 300 Milwaukee area plants. Challenging position with great future for advancement. Excellent salary — many fine benefits including liberal profit sharing plan. Replies held in strictest confidence. Write Box 12, ℅ MSMS.

Positions wanted

GENERAL SURGEON, 53, seeks salaried position full or part time. Clinical, academic, hospital-based. Open to all offers. Reply to MSMS, 120 W. Saginaw, Advertising, Box 20, East Lansing, MI 48823.

Miscellaneous

MEDICAL FACILITY AND NURSING HOME for sale. 100-bed skilled nursing home and full service medical facility, licensed for M.R. residents. Mid-Michigan, beautifully designed and maintained, operating at full capacity. Large medical practice, includes patients from general area and residents of home. Call or write Stephen Devich, Partridge Real Estate Inc., 1050 W. Huron St., Pontiac, MI 48053, 313/681-2111.

MEDICAL FACILITY FOR SALE or lease located in the north Detroit Metropolitan suburb, west of I-75. This twin complex is separated by a fully decorated and carpeted waiting room. The facility features seven rooms plus a receptionist area. There are five examination rooms, four with sinks, a lab with sink and a conference or X-ray room. Additional features include off-street asphalt parking lot, carpeting throughout, air conditioning, ample storage space and optional RCA room-to-room phone system with a built-in intercom and cross-trunk conferencing unit. For more information call 313/643-4965.

COMPUTER FOR SALE — L-8500 series Burroughs Computer for sale. Has 20K of memory with capacity of an additional 28K. Storage is on memory-stripe ledger cards for readable backup of patient accounts. Programmed for 1-10 physicians. Medicaid, Medicare and Blue Shield Insurance forms completed at the time of posting. Contact Bruce Davenport, MD, 2424 Spring Arbor Road, Jackson, Michigan 49203. Phone 517/787-6960.

FOR SALE — Picker 300 MA (used) fluoroscopic/radiographic unit with image intensifier & electric rotating table, $12,000. Call 616/962-6111.

OFFICE SPACE FOR LEASE between 14 and 15 Mile Road on Utica Road, Fraser. Summer of 1979. Next to golf course, airport. Across from hockey, racquet ball and tennis complex. Near St. Joseph West and South Macomb hospitals. 313/772-5070, 313/286-5757.

MSMS President Louis E. Heideman, MD, left, and AMA President Tom E. Nesbitt, MD, were silhouetted as they viewed Detroit and Canada from high in the Detroit Plaza Hotel during the 1978 Annual Scientific Meeting. For more details of the meeting see pages 11, 12, 14, 16, 17 and 18.

Plan of Work, Michigan State Medical Society

The following Plan of Work for 1978-79 is based on 1978 House of Delegates resolutions. These are in addition to ongoing efforts and projects and are not arranged in any order of priority:

1. To pursue cost effectiveness without sacrifice of quality health care.

2. To continue concern for the ethical and disciplinary aspects of medical practice.

3. To continue the study of health care delivery — monitor and evaluate HMOs and study feasibility of Individual Practice Associations.

4. To study the feasibility of utilizing the new MSMS computer to record CME credits for members.

5. To increase involvement in health planning by providing substantive support to physicians involved in health planning activities.

6. To increase communication with the membership and the House of Delegates.

7. To continue efforts to achieve stated MSMS policies.

8. To promote the idea of positive health strategies such as patient education.

Bureaucratic over-regulation treats physicians as children

If the opinion stands of the FTC law judge in the AMA/Connecticut State Medical Society and New Haven County Medical Association vs. FTC suit, we physicians will be in the position of the child who is barely permitted to breathe without maternal permission. The opinion reflects the worst kind of bureaucratic over-regulation, taking over all of the responsibilities which until now have been accepted as professional functions and responsibilities. First reading of the opinion raises a number of constitutional questions.

Comparable attitudes prevail in other situations. HEW has a propensity for underestimating the cost of programs and overestimating the savings to be achieved through regulatory control. Medicare is a prime example of underestimation of cost, probably deliberately done in order to get acceptance of the program by the legislature. The original projections were that ⅛ percent tax taken on the first few thousand dollars of salary by the employee and by the employer would be adequate to finance the Medicare program. The AMA and the Health Insurance Institute estimated the cost would be one percent for each. The tax was set originally at ¼ percent. The AMA and HII estimates were correct except that the impact of inflation was underestimated.

On the other side of the coin, the cost of PSRO was underestimated and the savings to be achieved overestimated. A similar pattern can be expected in the implementation, if it occurs, of generic prescribing. I suspect the same will be true of any effort to eliminate all inappropriate use under Medicaid and Medicare — the cost of the program will equal or exceed the savings. Lest my intent be misinterpreted, I hasten to point out that policing is necessary and that fraud and near-fraud are completely unacceptable and must be exposed. This, however, can be achieved without the apparatus necessary to achieve total control.

To paraphrase Ralph Waldo Emerson, "The best regulation is the least regulation."

Rules are necessary if people are to live in a society so that we may know what we can reasonably expect of each other. But regulation has the potential of becoming an end in itself, and becomes self-defeating by converting the process to a game of "beat the regulation."

The justification presented for many of the regulations which are being imposed is that health care does not follow free market rules and can't correct itself.

Louis E. Heideman, MD
MSMS president

The problem here is that those who propose the regulatory approach do not understand the health market. They don't understand its mechanisms, the extent of previously unmet need, and the time necessary to demonstrate results. Like children, they demand immediate gratification. Failing to receive it, they tinker with the system so that market forces never come into operation.

We ask that the government stop treating us as children who haven't learned the rules. Let us function as reasonable, responsible and responsive human beings, which the overwhelming number of physicians are. Let us provide the necessary services.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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the Bactrim™
3-system counterattack

ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of res tant organisms. Thus, Bactrim reduces the risk of intro colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the
urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

ULES

IDE THIS ISSUE is a spe-
l report on health plan-
g, with emphasis on the
MSMS Physician/HSA Sup-
t Center. Learn the
est details from the re-
t on pages 2 and 3.

* * *

S STAFF MEMBERS have been
igned to carry on activi-
following the departure
former deputy director
ert A. Auer. Mr. Auer be-
executive vice president
he Michigan Health Council,
Lansing on Jan. 2. Mr.
's long-time assistants in
r MSMS activities have
named to head those duties.
ry L. Fent is now Coordina-
of Physician Education.
yn G. Scholten is now
f of the Office of Commun-
ions. Judith E. Marr con-
es as editor of Michigan
icine and Medigram. Bruce
Ambrose will serve as ad-
r to the three. Continu-
as physician leaders and
mittees to set guidelines
the staff are Carl F. Ham-
strom, MD, chairman, CME
gramming Committee; Samuel
McMahon, MD, chairman,
al Scientific Meeting;
s H. Tisdel, MD, chairman,
mittee on Publications, and
as C. Payne, MD, chairman,
mittee on Public Service.

PERATION OF MICHIGAN PHYSI-
NS is needed now to assure a
rent two-year study of Michi-
health manpower is complete.
Michigan Health Council Man-
er Study asks physicians in
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t counties to complete and
urn the preliminary survey
led Jan. 16. Please return
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lth Manpower Survey, Suite
, Nisbet Bldg., 1407 S.
rison Rd., East Lansing
23.

BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine

Medigram

VOL. 78, NO. 3 JANUARY 29, 1979

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MSMS Council highlights

At its Jan. 24 meeting, the MSMS Council:

1) Authorized the Medicaid Liaison Committee to join the Michigan Hospital Association, if so indicated, in efforts to assure good Medicaid cost containment measures. Current state cost containment efforts result from cutbacks in the the 1979 Medicaid budget and include prior authorization of elective hospital services.

2) Supported goals and objectives of a grant application by the MSMS Bureau of Economics to the Kellogg Foundation to aid Michigan physicians in carrying out cost effectiveness guidelines established by MSMS, to measure the guidelines' effectiveness and to provide Michigan physicians with cost analysis of office procedures on a consultant basis.

3) Re-elected to the MSMS Board of Managers David Siegel, MD, for a two-year term, and Arthur A. Ulmer, MD, for a one-year term.

4) Heard a report on the implications of Michigan's new hospital bed reduction statutes by Hermann A. Ziel, MD, chief, Bureau of Health Care Administration, Michigan Department of Public Health, and by Jay Endsley, director, Office of Health and Medical Affairs.

5) Heard a report from Donald K. Crandall, MD, on physician work group efforts with Blue Cross/Blue Shield of Michigan. The Council discussed the report at some length and will undertake further study Feb. 7.

New Judicial Commissioners elected

New members of the MSMS Judicial Commission are John H. Doran, MD, Detroit, from District One; and Richard J. McMurray, MD, Flint, from District Four. Doctor McMurray has been filling the unexpired term of Richard Rapport, MD, Flint, who recently was elected to the MSMS Council. Re-elected from District Six is William C. Baum, MD, Holland.

Health Planning Update

By Dennis Paradis, director, MSMS Physician/HSA Support Center

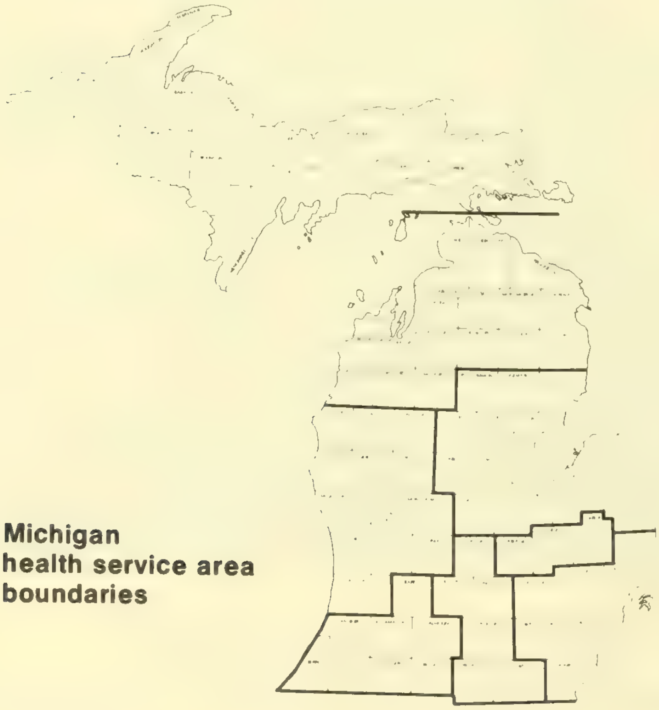
Mr. Paradis

The following special report describes recent developments on the Michigan health planning scene, including growth of the MSMS Physician HSA Support Center. The HSA Support Center is an important and growing function of the state medical society and is designed to place Michigan physicians in the mainstream of health planning activities in the state.

The Physician/HSA Support Center

The Physician/HSA Support Center became operational on Nov. 13, 1978. The Support Center was created by the MSMS Council to implement House of Delegates Resolution 78A-53 which called for an intensified effort by MSMS in the health planning field. Some of the proposed activities of the Support Center are:

- Serve as staff to the MSMS Steering Committee on Health Planning.
- Develop a presentation to explain the health planning process to groups of physicians.
- Facilitate the development of regional physician advisory committees to relate to each HSA.
- Monitor state and federal activities to provide physicians with the most current information about health planning issues.
- Assist physician committees in formulating and conveying positions to the HSAs.



Michigan health service area boundaries

The federally-mandated health planning process is playing an ever-increasing role in the practice of medicine. It is essential that physicians become involved in this process if the views of the medical profession are going to be reflected in the health planning process.

Development of physician advisory committees

In the summer of 1978, physicians from the seven counties that comprise the HSA in southeast Michigan (CHPC-SEM) met to discuss their need to relate to the federally-mandated health planning process in a unified manner. The result was the development of the "Seven-County Health Planning Advisory Committee" chaired by James Fryfogle, MD, Detroit. The committee provides a focal point at which representatives of medical and osteopathic component societies in southeast Michigan can meet to discuss issues they face in health planning. With the "seven county committee" as a model, and the newly created Physician/HSA Support Center as a catalyst, discussions have begun in other HSAs about the need to develop similar advisory committees.

As a result of these discussions, a statewide seminar for physicians involved in health planning is being proposed by the Physician/HSA Support Center. The purpose of the seminar would be to provide a forum for the discussion of the desirability and feasibility of forming physician advisory committees in other HSAs.

Physicians are becoming increasingly aware that the activities of the HSA are impacting on the practice of medicine, but do not know how to make their views heard. It is hoped the development of physician advisory councils to relate to each HSA will provide each physician, component society and specialty society with mechanisms to participate in the health planning process. If you are interested in starting or participating in such a committee in your area, contact Dennis Paradis, director, Physician/HSA Support Center, 120 West Saginaw Street, East Lansing, 48823, telephone (517)-337-1351.

Here are reports of activities in other health planning areas:

State Health Plan

The goals of the proposed State Health Plan were adopted by the Statewide Health Coordinating Council (SHCC) at its December meeting. The adopted goals are significantly different from the proposed goals in many cases. Involvement by MSMS accounted for several changes among the goals that most directly affected physicians. Final approval of the SHP was projected for the Feb. 8 SHCC meeting at the time of this writing. Since e State Health Plan is intended to be a policy statement Michigan health priorities, the Michigan legislature ssed a law requiring that the State Health Plan be subitted to the governor and the legislature for approval A 323 of 1978). It is assumed the governor will approve e plan, but the response of the legislature is not prectable. The statute requires the legislature and the govnor to approve or disapprove the State Health Plan ithin 45 days. A disapproval would send the SHP back the SHCC for modification. Approval by the governor d legislature will send the SHP to the secretary of HEW hich is the final step of the federally-mandated health anning process — until the required annual update.

eduction of excess hospital beds

The passage of the Public Health Code (PA 368 of 1978) cluded a provision for the elimination of excess hospil beds. The statute calls for the Michigan Department of blic Health to determine where excess hospital beds ist, and the federally-created Health Systems Agencies develop a plan for the elimination of these beds and en enforce that plan through the certificate of need echanism. The planning phase of this scheme mandated statute to be completed by 1980 and the excess hospil beds are to be planned for elimination within five ears.

The motivation behind the reduction of excess hospital eds is cost containment. It is estimated there are about 000 excess hospital beds in Michigan and the closure of ese excess hospital beds will result in a savings of hunreds of millions of dollars annually. About 50 percent of e estimated excess hospital beds are in the greater Deoit area. Other urban centers also account for a large ercentage of the estimated excess hospital beds, alough there are also overbedded rural areas.

This issue has generated much activity in the health lanning arena. The governor has fulfilled a statutory andate to create a Task Force on Hospital Capacity Reuction which held its organizational meeting in Deember. The charge to the task force is to address issues ch as capital indebtedness, legal obligations, unemloyment and provider displacement, which will develop s a result of the elimination of excess hospital beds. The edical profession is represented on the Task Force by illiam Unkefer, MD, Farmington.

The SHCC has created an ad hoc committee to review e guidelines prepared by the Michigan Department of ublic Health to define excess hospital beds. This comittee is currently meeting to suggest modifications in e proposed guidelines. The medical profession is represented on this ad hoc committee by Robert Toteff, MD, Saginaw.

The elimination of excess hospital beds will develop into a major issue in health politics and health care delivery. Physician involvement in this issue, both in the current developmental phase and the future planning phase, is essential. In recognition of this, the MSMS Council requested Herman Ziel, MD, of the Michigan Department of Public Health and Jay Endsley, of the Office of Health and Medical Affairs, to explain this activity at the Council's January 24 meeting.

EMS categorization

The passage of the new Public Health Code (PA 368 of 1978) reenacted the EMS statutes. This requires that the rules for EMS restart the process toward promulgation. The Department of Public Health has already initiated this process by calling together an informal review committee for EMS rules. The medical profession is represented on this committee by Ronald Krome, MD, of Detroit. A public hearing on the proposed EMS rules is scheduled for 10 a.m. Feb. 27 at the Michigan Department of Public Health, 3500 North Logan Street, Lansing. Copies of the proposed rules are available by contacting the Division of Emergency Medical Services, PO Box 30035, Lansing, (517)-373-1406.

On Jan. 8 the Governor named the members of the Statewide EMS Advisory Council. The appointments are still awaiting Senate confirmation. The medical profession is represented on the council by C. Mark Vasu, MD, Grand Rapids, and John G. Wiegenstein, MD, Lansing.

The appointment of the advisory council will precipitate a review of the criteria for the categorization of emergency rooms. Due to the long delay in the appointment of the council, the categorization criteria were developed without the benefit of advisory council consultation. The review of the categorization criteria by the Statewide EMS Advisory Council should provide an arena for the discussion of the many concerns that have been expressed. In recognition of the concerns surrounding the categorization criteria, the MSMS Council approved a motion at its December meeting to create a committee to develop liaison with the Michigan Department of Public Health regarding the categorization of hospital emergency rooms. Committee members have not yet been appointed.

CAPSULES/continued

IF YOU'D LIKE TO KNOW the experts' views on management of the obstetrical and pediatric high risk patient, on genetic screening, bonding and home deliveries, register now for the 1979 Michigan Conference on Maternal and Perinatal Health. The Feb. 28-March 1 event is scheduled at the Hyatt Regency Dearborn, and is sponsored by MSMS and nine other organizations. A registration form was printed in the Jan. 12 issue of Medigram. Housing reservations must be made directly with the hotel, 313/593-1234. Further information is available from Katie Brewbaker at MSMS headquarters, 517/337-1351.

* * *

MSMS IS BEGINNING THIS MONTH to test possible standards being developed by the AMA for health care delivery in juvenile homes across the state. This is in conjunction with the MSMS project to implement standards for county jail health care which has resulted in four of the state's county jails being accredited by the AMA. Three more are requesting surveys for accreditation.

Doctor Payne heads MDPAC; Doctor Berglund on AMPAC board

Thomas C. Payne, MD, East Lansing, is the new cha
man of the Michigan Doctors Political Action Comm
tee (MDPAC). Doctor Payne succeeds Thomas R. Ber
lund, MD, Portage, who completed four years as ch
man, and recently was appointed to the American
Political Action Committee (AMPAC) board. Succee
Doctor Payne as MDPAC secretary-treasurer is Robe
E. Paxton, MD, Fremont. MDPAC tied for first pla
among all state medical society PACs for the larg
gain in 1978 in sustaining members, and was secon
highest in all membership recruitment categories.
MDPAC has 3,242 members with 128 of them sustaini

MSMS pledges involvement at certificate of need conference

MSMS testified Jan. 23 before health care organiz
tions concerned with certificate of need applicati
The Michigan Department of Public Health convened
meeting. Blue Cross/Blue Shield of Michigan was h
Pledging MSMS involvement to joint efforts to deve
"a reasonable approach" (MDPH language) to review
and actions on certificate of need, were Louis E.
Heideman, MD, MSMS president, and David Siegel, MD
Lansing, chairman, MSMS Medicaid Liaison Committee
Also concerned with "the prudent use of resources"
(also MDPH language) in light of certificates of n
were the Michigan Hospital Association, HSA direct
osteopathic physicians, motor companies, UAW, MDPH,
BCBSM and Greater Detroit Area Hospital Council.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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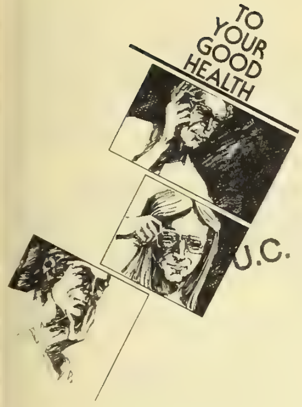

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 4 FEBRUARY 9, 1979

SHCC studying excess bed rules; expected to OK proposed health plan

As this Medigram was going to press, the Statewide Health Coordinating Council had scheduled a Feb. 8 meeting to discuss the guidelines and criteria for eliminating excess hospital beds, according to the provisions of the new Michigan public health code. The SHCC also was expected to give final approval to the new Preliminary State Health Plan, and send it to the legislature for discussion. If approved by legislature and governor, the preliminary plan is designed to serve as the guide for all health planning in Michigan for the next five years, with annual revisions required. The preliminary plan now contains considerable modifications to the original drafted by the Office of Health and Medical Affairs, including several changes supported by MSMS.

MSMS watching Medicaid cost cuts

Current cost containment efforts by the state must be made due to cutbacks in the 1979 Medicaid budget. MSMS is continuing to closely monitor those Medicaid cost containment measures to assure they will be consonant with good medical care.

MSMS task force on abuse at work

The MSMS task force on medical abuse and overutilization has begun its work to study alternative solutions. On the committee are Gerald Mandell, MD, chairman; William S. Carpenter, MD, Detroit; Edward E. Elder, MD, Pontiac; Robert H. Hamburg, MD, Detroit; Charles O. Long, MD, Lansing, and Richard L. Rapport, MD, Flint.

In this issue . . .

1. Maternal Health Conference registration
2. Application for MSMS volunteer physician legislative network

18th Annual Michigan Conference On Maternal And Perinatal Health

(Sponsored by MSMS and nine other organizations)

Approved for:
11 Category I Credits
11 AAFP Prescribed Credits
13 MNA-CEARP Contact Credits

An outstanding national authority will open the Wednesday morning and afternoon sessions with a comprehensive presentation on the subject matter to be covered. Following his presentation, three different case histories relating to the subject will be presented by three different panelists. The case histories will then be discussed by the presenter, other panelists, and the featured main speaker, with input from the audience invited.

Wednesday, February 28

(Maximum of 6 hours Category I Credit)

8:30 a.m. "Patient Profiles — The Mother"

Presiding: Bruce A. Work, Jr., MD, Ann Arbor, Co-chairman of Conference Planning Committee.

Featured Speaker: Irwin R. Merkatz, MD, Professor of Reproductive Biology, University Hospitals of Cleveland, Cleveland, "Obstetrical High Risk Patient"

Case History Panelists: Clinton H. Dowd, MD, Flint; Miriam F. Daly, MD, Albion; Nancy Schenk, RN, Ann Arbor.

1:30 p.m. "Patient Profiles — The Baby"

Presiding: John W. Hallitt, MD, Flint, Co-chairman of Conference Planning Committee.

Featured Speaker: L. Joseph Butterfield, MD, Director of Perinatology, Children's Hospital, Newborn Center, Denver, "Pediatric High Risk Identification and Stabilization."

Case History Panelists: James D. Johnston, MD, Traverse City; Donald DeWitt, MD, Kalamazoo; Rochelle M. Igrisan, RN, Petoskey.

Thursday, March 1

(Maximum of 5 hours Category I Credit)

8:30 a.m. "After the ICU — After the Nursery"

Presiding: Mary A. Scoblic, RN, MDPH, Lansing.

Featured Speakers: William J. R. Daily, MD, and Lester E. Mayes, MD, Co-Directors, Arizona State Newborn Transport and Intensive Care Program, Phoenix, "Development of Regional Intensive Care Center in Arizona;" Jess G. Thoene, MD, Assistant Professor of Pediatrics, University of Michigan Medical School, and Coordinator, Genetic Screening Program, Michigan Department of Mental Health, Ann Arbor, "Genetic Screening for Mental Retardation;" Pamela M. Fitzhardinge, MD, Director, Neonatal Followup Program, Hospital for Sick Children, Toronto, "Bonding — Followup on Infant's Discharge from Neonatal ICU;" Irwin R. Merkatz, MD, Professor of Reproductive Biology, University Hospitals of Cleveland, "Importance of Maintaining Lines of Communication Open to the Mother."

1:30 p.m. "Changing Concepts"

Presiding: Lee B. Stevenson, MD, Farmington Hills, Chairman of MSMS Committee on Maternal and Perinatal Health.

Featured Speakers: Dennis Paradis, MSMS Physician/HSA Support Center, "Health Planning: Its Impact on Maternal & Perinatal Health;" Warren H. Pearse, MD, executive director, ACOG, Chicago, "Facts and Fantasies of Home Delivery;" George I. Lythcott, MD, HEW Health Services Administration, Washington, DC, "HEW's Relationship to Maternal & Perinatal Care."

Hyatt Regency Dearborn

ADVANCE REGISTRATION

Please complete and mail to the MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH, P.O. Box 950, East Lansing, MI 48823.

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Please check one:
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		Physician	Nurse	Student/House Officer
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MSMS members: Please complete and return to MSMS this form to join volunteer legislative network

I hereby submit my application for the volunteer physician legislative network. (I realize such participation will help expand my MSMS legislative knowledge and will help MSMS continue personal MD contacts with legislators.)

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E. County Society ______________________________

F. Membership in Specialty Society
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G. Michigan State Medical Society
   1. Offices held, committee appointments: ______________________________
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H. Party Affiliation
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B. I'll come to Lansing to help MSMS:
   1. Number of times per year: ____
   2. Number of hours needed to reach Lansing: ____

C. I'll attend MSMS legislative workshops and training sessions.
   Yes ____ No ____ As often as I can ____

D. At this time, I will be able to participate in the program on the following date(s): (Due to legislative scheduling, your participation would be most effective on Tuesdays, Wednesdays and/or Thursdays.) The legislature convenes mid-January to July 4.
   First choice: ______________________ Second choice: ______________________
   Third choice: ______________________

E. Legislators I know personally:
   ______________________ ______________________
   ______________________ ______________________

CAPSULES

MSMS SECRETARY ROBERT M. LEITCH, MD, is expected to leave St. Joseph Mercy Hospital, Ann Arbor, soon after a brief illness. He will continue his recovery at home. Doctor Leitch is also past president of MSMS.

* * *

PLANS ARE MOVING ALONG for the 13th annual MSMS Conference on Medical Aspects of Organized Athletics. The conference is scheduled April 12 at Towsley Center, the University of Michigan Medical Center. Chairman is Gerald A. O'Connor, MD, Ann Arbor, U-M team physician. Team physicians, coaches and trainers are invited to the event. Information is available from Mert Scholten at MSMS headquarters.

* * *

Medical emergencies and medical legislation are highlighted in the February issue of Michigan Medicine. Leaders of specialty societies contributed to a "special section" devoted to treatment of medical emergencies, while the MSMS Division of Government Relations prepared the report on the progress of medical legislation through the last legislature.

Lansing HMO selected for AMA study of quality, cost

Health Central of Lansing is one of 15 HMOs around the country to be selected for site visits by the AMA Department of Professional Review in cooperation with the AMA Council on Medical Service. The AMA delegation also is scheduling a meeting with the Ingham County Medical Society in its study of HMOs and their impact on access, quality and cost of health care. The AMA House of Delegates has called for an objective assessment of HMOs, including IPAs and other group arrangements. A report of the study including the survey of the Lansing HMO (which is of the IPA type) will be made to the AMA House in June.

HEW recommending chiropractic be dropped from Medicare, Medicaid

To meet the Carter administration's call for keeping federal health care spending to a minimum, HEW will recommend legislation to eliminate Medicare and Medicaid payments for chiropractic services. American Medical News quotes the HEW as believing, "In the absence of scientific evidence that chiropractic services either improve or maintain health status, HEW believes that chiropractors should be removed from the list of eligible providers."

AMA urging MDs fully report services provided on Medicare billin

The AMA is urging medical societies to remind physicians that AMA policy on direct billing under Medicare calls on every MD to "report fully and specifically in his billing the nature of the services provided so that the patient may be properly reimbursed by the Medicare carrier" and "to guide his patient in his application for reimbursement."

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 78 No. 4, February 9, 1979

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Editor: Judith Marr

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JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

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Contents

Michigan Medicine

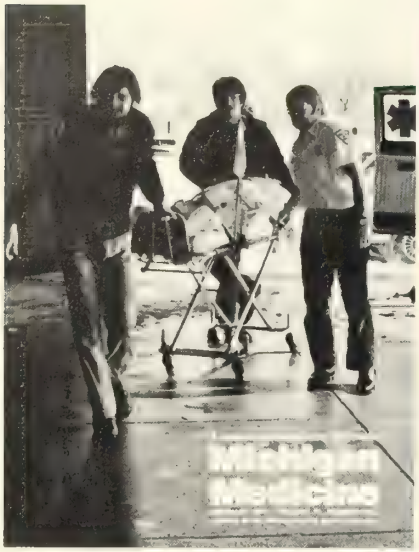
PHOTO BY MERT SCHOLTEN

An emergency medical team brings a heart attack victim into the Ingham Medical Hospital Emergency Department. Emergencies and their management are the topic of this month's special section beginning on the facing page.

Special section

61 **What's a typical emergency in the field of surgery? In the fields of obstetrics/gynecology and psychiatry? How is the field of emergency medicine itself? These questions are taken up in this month's special section by the leaders of those specialties. Further discussion will follow in the March issue;** Charles W. Aldridge, MD; Bruce L. Danto, MD; Peter A. Duhamel, MD; John H. van de Leuv, MD

Features

68 **Report on the Michigan medical arbitration system;** Rhoda M. Powsner, MD

71 **Review of medical bills introduced in 1977-78 Michigan legislative sessions**

76 **Tributes to Herbert A. Auer;** Louis E. Heideman, MD; Louis R. Zako, MD; James H. Tisdel, MD; Warren F. Tryloff

86 **Progress report on the MSU School of Osteopathic Medicine;** Myron S. Magen, DO

106 **Unique new computerized heart cath lab at Ingham Medical;** Irma Kaufman

Departments

66 **MSMS Q/A**
77 **MPMLC clipsheet**
83 **Category I courses**
84 **Meetings**
95 **Letters**
96 **Business**
98 **MSMS Auxiliary**
100 **News**
103 **Welcome**
104 **Ad index**
108 **Classified ads**
109 **Deaths**

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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Emergency physicians organizing to ensure competent care to ER patients

By John H. van de Leuv, MD
Dayton, Ohio

Editors' note:

The following articles present several specialists' views of medical emergencies in their fields — obstetrics/gynecology, psychiatry and general surgery. In addition, the immediate past president of the Michigan Chapter, American College of Emergency Physicians, talks about the emergency medical field from his view. We plan to continue the dialogue on what constitutes an emergency, how to handle it and whether or not emergencies currently are being handled well, as members respond in future issues of the journal.

Emergency medicine has matured rapidly — not prematurely, just rapidly. The most prominent reason for this is a demand for the services rendered in the nation's emergency departments.

There are many explanations for this increasing demand. First is the desire of the patient or his relatives and friends not to wait for an evaluation of the problem at hand. This is recognized by the legislature, which has written in the Emergency Medical Services Act that it is the patient who determines what constitutes an emergency.

Many other reasons for the upsurge of care in the ED have been given. Among these are a lack of opportunity to receive care from primary physicians, the mobility of the population, the 24-hour accessibility of the ED, the complete range of studies available in the ED, mistaken concepts of disease processes, anxiety and perhaps guilt feelings on the part of the parents, and, in the last few years the knowledge that ED's are staffed by more competent physicians.

All of this had led to the rapid development of emergency medicine as a specialty, which seems to have entered in its final phase of approval for specialty board recognition. Emergency physicians are ready to sit for their examinations by the Board of Emergency Medicine. The examination is ready also. There is no grandfather clause recognized by the American Board of Emergency Medicine, so all physicians who want specialty status will have to pass the examination. This is good! It will mean all physicians board certified in emergency medicine will be considered qualified by one of the most innovative, strict and comprehensive methods of examining medical practitioners.

All this will mean the segment of the population seeking care in the emergency department, be it for a life-threatening condition or a simple illness or injury, will receive competent care from well-qualified physicians. Eventually the house of medicine will be able to count on this as a part of the normal course of medical care.

There are many who are not willing to recognize emergency medicine for what it is worth. We know this and we are going to prove them wrong. We have accepted the challenge of making emergency medicine a discipline which will be an important segment in the pie of American medicine. It will be so!

Doctor van de Leuv is immediate past president of the Michigan Chapter, American College of Emergency Physicians.

General surgeon can lead the team; particularly needed for abdominal trauma

Doctor Duhamel

By Peter A. Duhamel, MD
Rochester

The general surgeon is the doctor most frequently called by the emergency physician to come into the Emergency Room. Depending on the size of the hospital staff, and the availability of such specialists as orthopedists, neurosurgeons, urologists and plastic surgeons, the GS may be responsible for from 40 percent to about 70 percent of the emergency patients who are admitted to the hospital.

The general surgeon is especially needed in the evaluation and treatment of all types of trauma. Of course, the GS's forte is the care of abdominal trauma, both blunt and penetrating.

It most commonly has been held in the past that all patients with penetrating abdominal injuries required immediate laparotomy. However, recent experience from many medical centers has shown that a large number of patients with stab wounds would have completely negative explorations, and many others have relatively minor injuries to the omentum or liver which would do just as well if a laparotomy were not done. So, except for the patients with obvious peritoneal signs of spillage of intestinal contents or pancreatic enzymes or gross intraperitoneal hemorrhage, the stab wound patients now are frequently being admitted and observed much the same as the patients with non-penetrating wounds. In fact, there are now appearing some reports of patients with gunshot wounds of the abdomen who are being treated nonsurgically.

Abdominal trauma challenge

The patient with blunt abdominal trauma can present a difficult challenge to the general surgeon. The decision whether to operate and when to operate can depend on a number of factors: the experience of the particular surgeon; the availability of proper assistants and consultants, if needed; the facilities for continued observation, such as 24-hour laboratory, blood-bank and radiology personnel; and operating room and anesthesia staffing. But most of all this decision depends upon the condition of the patient as determined by thorough initial evaluation and frequently repeated observations.

Many of the patients with blunt abdominal trauma will have evidence of peritoneal irritation or significant intra-abdominal injury at the initial examination, so that the decision to operate will be obvious. However, the patient who has a soft abdomen with normally active bowel sounds at first examination and then gradually develops a localized area of abdominal pain, tenderness, guarding and rebound in that area with decrease in his peristaltic activity will need to be diligently watched.

Besides repeated careful examinations of the abdomen by the surgeon and monitoring the vital signs and laboratory work (hemoglobin, hematocrit, white blood count and urinalysis), the most valuable diagnostic tool in the evaluation of possible need for surgery is the peritoneal lavage. There are a number of techniques of doing peritoneal lavage, depending on the training and experience of the surgeon. But this procedure can usually provide the necessary information on the presence or absence of significant intraperitoneal hemorrhage.

Routine initial care of these patients would include passing a naso-gastric tube with aspiration and inspection of the gastric contents (blood, alcohol, undigested food), insertion of a Foley catheter, putting in one or more large intravenous lines, drawing of usual laboratory work including CBC, urinalysis, amylase, blood sugar, electrolytes, and type and cross match. Frequently a central venous pressure catheter is indicated.

A brief medical history should be obtained from the patient or relatives, including the circumstances of the accident (to reconstruct the mechanism of trauma to determine if any additional injury is likely), what medications the patient may be taking (insulin, steroids, anticoagulants, digitalis, anti-hypertensives), any significant previous illnesses or operations, when he last had anything to eat or drink, and what allergies he may have to medication. Any coexisting medical conditions should also be considered in the over-all treatment plan, especially diabetes, cirrhosis, congestive heart failure and emphysema. These may also influence the timing of surgical intervention.

Spirit of cooperation

The patient with multiple injuries presents a wide range of problems for the general surgeon and all the other surgical specialists participating in his care.

In many hospitals it is the policy that a general surgeon be the primary physician in charge of a patient with multiple injuries, even in those cases when there is no obvious intra-abdominal or intrathoracic trauma.

There are a number of reasons for such a policy: first, the initial and continuing assessment of the patient must be thorough to determine if there are any other less obvious, but potentially life-endangering injuries; second, someone must write the continuing orders for this patient considering all of the involved systems and underlying conditions; thirdly, someone must be the quarterback of the team to call the plays.

In most hospitals the treatment of multiple injuries can be carried out in the spirit of friendly cooperation for the ultimate good of the patient.

Doctor Duhamel is president, Michigan Society of General Surgeons.

Obstetrical, gynecologic emergencies and their handling

By Charles W. Aldridge, MD
Grand Rapids

The modern trend in obstretrics is to identify patients who are likely to develop serious complications during the antepartum, intrapartum or postpartum stages by a process of "risk scoring." Then, through the organization of a regionalization concept, these patients should be assigned for care to a Level I, II or III facility which would be equipped to most effectively manage those complications which are likely to occur. Many professional health organizations are working on the development of a sophisticated network for regionalization of obstetrical and perinatal care in Michigan.

Obstetrical emergencies

ANTEPARTUM

Abortion; spontaneous, incomplete. Passage of the products of conception prior to 20 weeks gestation can be associated with life-threatening hemorrhage. Any bleeding occurring during early pregnancy is abnormal and demands that a pelvic exam be carried out, if this has not been done earlier in the gestation. If a previous exam has ruled out other causes of bleeding, such as cervical polyps, pelvic exam is probably best deferred when bleeding is less than the normal menstrual flow.

If bleeding is persistent or heavier than a period, visualization of the cervix and a digital exam for cervical dilatation should be done promptly. Delay in doing so would be an invitation to disaster. When tissue is seen or felt presenting in the cervical os, prompt emptying of the uterus, usually as an out-patient, will avoid serious hemorrhage, infection and anemia. This will also result in the best prognosis for avoiding subsequent infertility and recurrent abortion.

Pregnancy tests are usually not helpful in the management of these cases. The test may be negative as in the case of a missed abortion or it may be positive for several days after the abortion has progressed to the inevitable stage.

INTRAPARTUM

Prolapse of the umbilical cord. In order to prevent this complication, one should avoid artifical rupturing of the membranes unless the fetal head is engaged and fitting snugly against the cervix and with a uterine contraction. In breech presentations, the membranes should remain intact as long as possible. One should always feel for the cord and monitor the fetal heart rate carefully immediately after the membranes rupture.

Once the diagnosis has been made, delivery must be effected as soon as possible. If the cervix is not completely dilated, a *stat* Cesarean Section should be done. The patient should be placed in a deep Trendelenburg or knee-chest position while preparations are being made. Usually it is helpful to hold the head up out of the pelvis manually until the incision is made. If the cervix is completely dilated and the head is at or below the spine, forceps delivery may be carried out by those thoroughly familiar with this type of operative vaginal delivery.

POSTPARTUM

Postpartum hemorrhage may be either immediate or delayed. Life threatening hypovolemic shock usually develops as the result of too little treatment too late. There is a tendency to underestimate the amount of blood loss. The patient will maintain her blood pressure at normal levels (in spite of excessive blood loss) because of vasoconstriction. Therefore by the time the blood pressure drops, the obstetrician is behind in his treatment.

Prevention of hemorrhage includes careful examination for cervical and vaginal lacerations after every delivery. Also, manual exploration of the fundus should be done if there is the slightest suspicion that there is any retention of placental tissue or membranes.

Because of the ever-present possibility of complications such as postpartum hemorrhage, a strong case can be made for maintaining an IV line with an 18 gauge needle or larger in every patient during labor and delivery.

Doctor Aldridge

If hemorrhage is due to uterine atony, primary treatment must be to correct the cause with IV oxytocics and immediate blood replacement with whole blood or packed cells. Blood expanders, such as pooled plasma or Dextran, should be used until blood is available. Occasionally an emergency hysterectomy may be required.

Gynecologic emergencies

Ruptured tubal pregnancy usually is an emergency that must be treated surgically immediately because it is associated with massive intra-abdominal hemorrhage. The presenting symptoms may be vague. Ectopic pregnancy mimics many pelvic disease states. Pelvic pain after one missed period is typical. Tubal pregnancies usually rupture before eight week's gestation. Therefore the onset of pelvic pain after two missed periods is unlikely to be due to ectopic pregnancy. Pain may be primarily rectal due to blood in the cul-de-sac. Shoulder pain due to irritation of the diaphragm with free blood in the abdominal cavity is a clue to the diagnosis when it is present. Syncope and shock are presented late in the course of this disease. Pregnancy tests will be negative in at least 50 percent of the cases.

Bimanual examination is often inconclusive. A useful diagnostic procedure is to needle the cul-de-sac vaginally with a large gauge, long needle. If free blood is obtained, ruptured tubal pregnancy is the most likely diagnosis.

Immediate blood replacement and surgery to stop the loss of blood is required when the tube has ruptured. Occasionally an unruptured tubal pregnancy can be diagnosed and non-emergency surgery can be carried out.

Doctor Aldridge is president of the Michigan Society of Obstetrics and Gynecology.

MD handling psychiatric emergencies must give specific, caring treatment

Doctor Danto

By Bruce L. Danto, MD
Detroit

The guidelines which the physician must apply to accurately and effectively evaluate a self-destructive type of emergency are not always clear. Specific questions and areas must be explored in order to determine whether or not either a suicidal crisis or type of self-destructive behavior is serious and requires more specific treatment than a single emergency room or office appointment type of evaluation.

Suffering from psychosis?

Most important for the physician to determine is whether the patient is suffering from a psychosis. When such a condition exists the patient will act in a bizarre or peculiar manner, will offer concrete answers like he knows who works in a hospital because he knows they're hospital people, may be confused and disoriented, may be listening to voices and looking around the room to see where they're coming from or may report visual hallucinations.

Such a patient will display a flattened or lifeless emotional tone and there may be either a well-organized thought disorder seen in terms of a delusional system or a thought disorder in terms of fragmented ideas which do not hang together.

If the patient shows these signs of behavior and has a peculiar story to explain his behavior, such as, he jumped into the river because voices warned him he would be cut to pieces, then we are dealing with a schizophrenia. On the other hand, if that magical story is missing and there is other history or findings such as drug abuse, thyroid disease, use of some anti-hypertensives or steroid drugs or other significant metabolic disease like diabetes, then other consultation and laboratory study is required.

Regardless of what has produced the psychosis with which the suicidal behavior is associated, this patient must be admitted to a closed psychiatric unit for control, study and treatment.

Some neurotic types of conditions associated with suicidal behavior are justifications for emergency admissions also. If the patient is deeply depressed and sees no hope or sense of future to his life save that either of death or exit then he needs the supportive milieu of a hospital structure. If he has been drinking heavily or has a serious weight loss or loss of appetite then short term hospitalization is necessary. And, of course, if there has been a serious type of suicide method utilized such as drug overdose with some brain stem depression or severe bleeding from a laceration, especially in a vital area like the neck, or effort to shoot himself regardless of a serious wound, then hospitalization is warranted.

Self-destruction intentional?

Admission is also advisable if the patient's self destructive behavior is intentional in regard to dying, is unconscious or sub-intentional with regard to heavy exercising with a serious heart disease or repeated crises during a diabetic condition. If the patient has made a serious suicide attempt in light of a dress rehearsal for death or has involved himself with organ mutilation such as amputation of the penis or a hand, mutilation of the vagina, evisceration of an eyeball or attempt at self-immolation with some flammable substance, such admission similarly must be considered. If the patient has made a suicide threat and has a background of at least one definite suicide attempt, regardless of how serious, plus insomnia and depression, admission must be considered. The chances that he will commit suicide in light of such a suicide threat are extremely high.

And, finally, if the patient has been injured because of a serious auto accident and has a history of other serious accidents or has provoked an assault, even a deadly one by another person such as a police officer, then he is a high-risk person and might not be aware of his self-destructive needs.

Whether or not the patient is admitted by the evaluating physician, that same physician or his social worker or psychiatric consultant must also evaluate whether the family or friends are interested in having this person live and take his suicidal threat or behavior seriously and empathetically.

That same office or hospital staff must ensure that family members are advised to remove firearms or lethal supplies of medication and are able to see where crisis intervention social work, psychological or psychiatric care is necessary and vital. The patient and his family as well as the evaluation staff or person must also be clear about instructions, about follow-up and resources and the patient should be contacted within three days to check on his progress and course of action in the event he has been discharged from the hospital.

The treating physician must make sure he avoids any decision which will limit his contact to a prescription for sedatives or tranquilizers alone and for directing the patient to contact some known or non-specific mental health resource. The price that he will pay for such indifference and non-specific intervention is a patient who feels medical personnel are telling him he does not deserve to live.

Doctor Danto is director, Suicide Prevention & Drug Information Center, Detroit Psychiatric Institute; and clinical associate professor, Department of Psychiatry, Wayne State University.

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And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

LIBRIUM® Ⓒ IV

chlordiazepoxide HCl/Roche

THE ANXIETY-SPECIFIC

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

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Manati, Puerto Rico 00701

MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

FOR: Edward S. Peterson, MD
AMA Department of Medical Education

"Are the odds any better these days for the applicants to medical schools? If so, or if not, can you elaborate?

The nation-wide odds on acceptance to medical school for applicants reached an all-time high during 1973-75 of one chance in three. For 1975, there were 42,303 applicants for 15,365 places. Since then the number of applicants has been declining and the number of places expanding, so that by 1980 the odds are expected to return to the ratio of one chance in two — a ratio that has tended to prevail for most of the past 50 years. In 1980, there are expected to be around 17,000 places with about twice that number of applicants.

Mr. Brennan

FOR: Bert Brennan, Executive Director
Michigan Board of Medicine

"I understand MSMS can arrange to have physicians or others present to monitor the Board of Medicine's hearings on MDs. Can you tell us what this arrangement is and how it works?"

At one time, the Medical Practice Act mandated at least two board members be in attendance at all formal board hearings. This was an impossible mandate which lead the Michigan State Medical Society to offer the services of their members to act as surrogate board members. The act was properly amended removing the required two members' attendance.

However, all board formal hearings are open to the public and MSMS members are more than welcome to attend. Unlike board members, they are not privileged to pose questions to witnesses nor participate in the proceedings.

Doctor Pomeroy

For: R. W. Pomeroy, MD, Lansing, Chairman
MSMS Committee on CME Accreditation

"How does a hospital go about being accredited for Category I CME courses?"

Organizations seeking accreditation of their continuing medical education activities should obtain a copy of the Accreditation Manual for Continuing Medical Education Activities in Michigan and an application. Outlined in the manual are the seven standards which must be functioning at the time of the survey, and the criteria which any Category 1 program should meet. Copies of the manual may be obtained by writing Marce Ireland at MSMS headquarters.

Application for survey and detailed information is submitted in the form of a presurvey questionnaire. The application fees are $150 for non-hospital based organizations and $250 for hospital-based organizations. Information submitted is reviewed by the Committee on CME Accreditation, and if acceptable, a survey team is appointed. Survey follows as soon as possible, usually within six weeks.

After survey, a report is made to the full committee, and the committee's recommendation regarding accreditation is forwarded to the national accrediting body.

Accept no substitute for your professional judgment

As a physician, you have the right to rescribe the drug which you believe ill most benefit your patients. Now, ubstitution laws make it more diffiult to exercise that right. In many tates, unless you specifically direct harmacists to dispense your brandame prescription as written, they ay be required by law to substitute nother drug for your brand-name rescription.

This means that the ultimate drug election is no longer yours; its ource is left to the pharmacist's disretion. You will have forfeited your ight to prescribe as you see fit. Preerve your rights. Specify that you will ccept no substitution.

When you accept no substitutes...

- You ensure that your patient receives exactly that product you have specified on your prescription
- You choose the quality of the product dispensed to your patient
- You can exercise the right to select a product based upon its proven therapeutic performance and to select a manufacturer that stands behind its brand name or generic product
- You can support the kinds of research programs that are vital to new drug discovery and development
- You can help sustain important physician, pharmacist and patient education services supported by innovative, research-oriented firms

For complete information on the drug substitution law effective in your state, please consult your local Pfizer Representative.

Pfizer **PHARMACEUTICALS**

Consultants to report April 1 on effectiveness of arbitration system

By Rhoda M. Powsner, MD
Ann Arbor

MSMS supported arbitration as one of the cornerstones in a new structure to resolve the professional liability crisis which cracked down on medicine in 1974. Today, we are deeply involved in its implementation.

The Michigan Medical Arbitration Program (Public Acts 140 and 141), which offers voluntary binding arbitration as an alternative to litigation, went into effect on Jan. 1, 1976.

Four groups affected

There are four major groups affected by the arbitration laws. First, the laws mandate that certain health care institutions, namely hospitals, clinics, sanitariums, and HMOs, offer the arbitration option to all treated or admitted patients. These institutions must also achieve participation levels with their staff, so that 75 percent participate at the end of the first year, 85 percent in the second year and 90 percent in the third year.

The second major area involved by the law is the independent physician's office practice. Participation in the arbitration program is optional for doctors in their offices. However, doctors with admitting or treatment privileges have been asked to participate in the institution's arbitration program to achieve the required participation levels. Doctors who are employees of the institution automatically are covered by the institution's agreement as are all other employees.

The insurance companies are the third major group involved by the law. Insurance companies are required to endorse all malpractice policies for hospitals, HMOs, clinics and sanitariums. The endorsement stipulates that the insured institution must meet the requirements of the law if the policy is to remain in effect. The insurers cannot refuse to offer insurance because a current or future insured party wants to participate in the arbitration program. In addition, the insurers must pay an assessment to finance the Arbitration Administration Fund, which is a fund run by the Insurance Commissioner to defray the cost of the arbitration hearing. In fiscal year 1977-78, assessments to the insurance companies for the fund were approximately $120,000. The 1979 estimated budget has been increased to $212,000.

The last major group involved by the law is the Michigan Insurance Bureau. Under the arbitration laws, the Insurance Bureau was required to establish an Arbitration Advisory Committee to advise the commissioner on all aspects of the arbitration program. The 18-member committee is composed of doctors, lawyers, hospital administrators and consumer representatives. The advisory committee developed the arbitration forms, Patient Information Booklet, criteria for arbitration, and an education and training program. This committee, in essence, oversees and directs the arbitration program in Michigan by advising the insurance commissioner on any policy and procedural changes.

Progress to date

To meet the statutory requirements for review and evaluation, the Arbitration Advisory Committee has established a Subcommittee on Evaluation. The Arbitration Advisory Committee and the Insurance Commissioner have contracted with the Arthur Young and Company to assemble and analyze data for a report on the effects of arbitration. The data will focus on acceptance, use, administration, cost and impact of the arbitration system.

The evaluation should provide baseline data for recommendations by the Advisory Committee in the two areas specified by the existing statutes: (1) Is legislative change needed or desired to make the program effective? Should the program be continued? (2) If the program is effective, what modifications are indicated to reflect such success, as in insurance premiums and other practices?

The Arthur Young and Company final report is scheduled to be presented to our Advisory Committee on April 1.

Case administration summary

The following arbitration case experiences are presented for your information:

Total Cases Filed to Date — 73

I. Geographic Locale
  41 involve incidents in tri-county area
  32 involve incidents in outstate Michigan

II. Representation
  59 attorney represents claimant
  14 claimant represents self

III. Respondents Named
  10 against doctor only
  26 against hospital only
  37 against hospitals and doctors jointly

IV. Closed Cases
  Total Cases Closed — 17
  Settled — 6
  Withdrawn — 7
  Decided by Arbitrators — 4
  In Favor of Defendant — 4
  Awarded — 1 Found Agreement not Valid (Spanish-speaking woman did not understand what she was signing, allowed to pursue litigation)

V. Additional Case Experience
  A. 17 cases alleged permanent injury due to incident
  B. 4 cases alleged resultant death due to incident
  C. Damages claimed, in all cases, range from a request for reimbursement of costs to $4,000,000

Doctor Powsner is a member of the Arbitration Advisory Committee to the Michigan insurance commissioner.

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COLACE

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Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

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This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

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Each capsule or tablespoonful (15 ml) liquid contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Liquid in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

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Here's what's happened to 1977-78 medical legislation

From the MSMS Division of Government Relations

In the 1977-78 session of the Michigan legislature, 74 bills were introduced which were of direct interest to medicine, most of which were health- or medical-related legislation. Twenty were passed. Of the remaining 54 not enacted, only 10 survived their houses of origin.

A highlight of the 1977-78 legislation was the enactment of the new Public Health Code. Legislation defining malpractice, the Governor's adherence to the principle of abortion services in Medicaid, Medicaid parity with Medicare, teaching of sexuality in public schools, and the more flexible three-year requirement for 150 hours of continuing medical education credit also marked the two-year session.

The Public Health Code recodifies all public health statutes, and incorporates the requirements for licensure and certification of all health professionals. This new act outlines the structure and powers of state and local health departments, and the various health professionals' disciplinary boards, and establishes a Health Occupations Council to oversee and coordinate the activities of the various health boards. Implementation of this new law will, in itself, be a long and difficult process requiring continued monitoring and advice from physicians.

Among medical-related pieces of legislation that were not enacted, were legalization of laetrile therapy for cancer patients, amendments to the Anatomical Gift Act, Medical Treatments Decision Act and expanded scope for chiropractors.

Following are cursory reviews of medical-related legislation that was enacted by the 79th session of the Michigan Legislature.

PUBLIC ACT 11 and 12 of 1977, introduced by Rep. Jeffrey Padden mandates that a person selected for jury duty would be called for a specific day. If not chosen for jury that day, his/her obligation would be met. If a person is selected, he/she would be required to serve for only a single trial. The act eliminates occupational exemptions, including physicians.

PUBLIC ACT 23 of 1977, introduced by Rep. Raymond Hood, removed language which was added to the Medical Practice Act in 1976 that two members of the board must attend all disciplinary hearings but cannot sit in final board deliberations of the case. Returns to the language requiring all hearings be administered under the Administrative Rules Act.

PUBLIC ACT 226 of 1977, introduced by Rep. Barbara Rose-Collins, lifts the prohibition on teaching birth control in the schools. It requires that qualified teachers be used and a citizen's advisory committee review all materials used in the class. Students could be excused from the class without penalty. The bill specifically excludes teaching of abortion as a method of birth control.

PUBLIC ACT 272 of 1977, introduced by Rep. E. Dan Stevens, defines malpractice as an injury caused by a physician's failure to provide the recognized standard of care for that community or a similar community for general practice, or national standards for specialties. The latter takes into consideration facilities that were available at the time the care was rendered.

PUBLIC ACT 42 of 1977, sponsored by Rep. Matthew McNeely, extends the Brown-McNeely Fund through July 1979. It provides for a stabilization reserve fund created by those physicians holding policies in order to reduce the possibility of a general assessment on all physicians in Michigan.

PUBLIC ACT 123 of 1977, introduced by Rep. Raymond Hood, creates a three-year period in which the physician must acquire a minimum of 150 hours of CME credit instead of 50 hours per year.

PUBLIC ACT 312 of 1978, introduced by Rep. Connie Binsfeld, mandates that within 10 days of the diagnosis of a critical health problem the physician shall file a report with the Department of Public Health. This report shall contain information the director of public health considers necessary to identify, locate, investigate the occurrence, frequency, incidence, cause, effect, and prognosis of the critical health problem.

PUBLIC ACT 297 of 1977, introduced by Rep. William Ryan, extends the interim approval for physician assistants until rules are finalized.

PUBLIC ACT 215 of 1977, introduced by Sen. Bill Huffman, requires the Michigan Board of Medicine to suspend the license of any physician for the conviction of Medicaid or Medicare fraud.

PUBLIC ACT 273 of 1977, introduced by Sen. Patrick McCollough, provides some relief for professionals on their single business tax liability. The average physician with an annual income of $58,000, gross receipts of $110,000, and employee compensation of $20,000 will realize approximately a $100 savings as compared to his 1976 tax liability.

PUBLIC ACT 472 of 1978, introduced by Sen. Gary Corbin, requires the registration and filing of reports by all lobbyists and their agents. This act is all-inclusive in the definitions of lobbying and will require the MSMS and county medical societies to register as lobbyists if they entertain legislators or members of the executive branch of government after they reach certain financial thresholds of expenditures.

PUBLIC ACT 447 of 1978, introduced by Sen. Daniel Cooper, provides that participants in Medicare programs have a mandatory conversion right to insurance programs for medical, hospital and surgical benefits.

PUBLIC ACT 105 of 1977, introduced by Rep. Melvin DeStigter, was the appropriation bill for the 1977-78 budget for the Department of Social Services. In Section 50 of this bill it states, "On October 1, 1977, the Department of Social Services shall increase fee screens for all physicians' services provided in an ambulatory setting to current Medicare screens." In other words, the 1978 appropriations establish parity between Medicaid and Medicare reimbursements for physicians' services in a hospital setting.

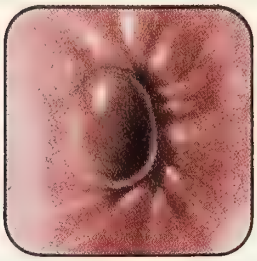
PUBLIC ACT 401 of 1978, introduced by Rep. Melvin DeStigter and Sen. Melvin Larson, is the appropriations bill for the Department of Social Services for 1978-79. The budget directives extend Medicaid parity with Medicare to include certain inpatient services as well as ambulatory services. The original act was subject to a Governor's line item veto of the entire Medicaid providers' allocation in order to veto a $1 ceiling on payments for abortion services. Subsequently the Legislature reenacted the appropriation with the $1 non-therapeutic abortion ceiling as a free-standing line, subject to Governor's veto without endangering the entire Medicaid appropriation. A separate piece of legislation introduced by Sen. Jack Welborn would have prohibited any payment for abortion services in the Medicaid program. This was enacted by the Legislature but subject to Governor's veto.

Senate Bills

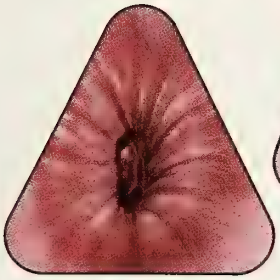
BILL NUMBER	PRIMARY SPONSOR	SUBJECT	STATUS
SB 15	**Huffman**	**Revocation of License for Conviction of Fraud**	**P. A. No. 215, 1977**
SB 124	**Toepp**	**One-Year Hospital Arbitration Agreement**	**Did Not Pass**
SB 139	**Davis**	**Transportation of Radioactive Materials**	**Did Not Pass**
SB 193	**Plawecki**	**Regionalize Blood Banks**	**Did Not Pass**
SB 337	**Kammer**	**Regulate Over-Counter Sedatives**	**Did Not Pass**
SB 347	**Hertel**	**Notification/Dangers: Ionizing Radiation**	**Did Not Pass**
SB 477	**Guastello**	**Earmarking Funds; Medical Practice Board**	**Did Not Pass**
SB 496	**Davis**	**Single Business Tax**	**Did Not Pass**
SB 613	**Allen**	**Prophylactic Display**	**Did Not Pass**
SB 674	**Corbin**	**Lobbyists Disclosure**	**Did Not Pass**
SB 683	**Geake**	**Fifth Pathway Program**	**Did Not Pass**
SB 734	**McCollough**	**Single Business Tax Reduces Rates**	**P. A. No. 273, 1977**
SB 821	**Otterbacher**	**HMO Advisory Commission**	**Did Not Pass**
SB 822	**Otterbacher**	**HMO Licensure**	**Did Not Pass**
SB 823	**Otterbacher**	**Prohibits Discrimination Against HMO's**	**Did Not Pass**
SB 829	**Welborn**	**Ban Abortions Under Medicaid (Social Service Appropriations)**	**Sent to Governor, veto expected**
SB 867	**Bishop**	**Canadian Physicians Obtain Michigan License**	**Did Not Pass**
SB 912	**Hertel**	**Hospitals Separate Surgical Facilities Required for OB pts.**	**Did Not Pass**
SB 924	**Otterbacher**	**Single Business Tax**	**Did Not Pass**
SB 925	**Otterbacher**	**Single Business Tax**	**Did Not Pass**
SB 926	**Otterbacher**	**Single Business Tax**	**Did Not Pass**
SB 1035	**Huffman**	**Divides State in 78 Health Facilities Service Areas**	**Did Not Pass**
SB 1038	**Otterbacher**	**Single Business Tax**	**Did Not Pass**
SB 1527, 28 1529	**Cooper**	**Supplemental Insurance Coverage for Fed. Health Care Recipients**	**Did Not Pass**
SB 1711	**Derezenski**	**Michigan Occupational Code**	**Did Not Pass**
SB 1735	**Geake/Faust**	**First Technical Amendments to Public Health Code**	**Sent to Governor**

(See page 74 for House bill action.)

For hemorrhoids and other anorectal conditions

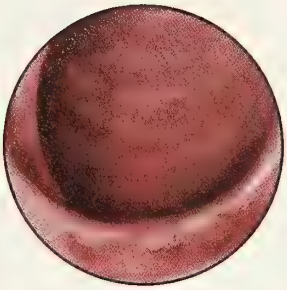


External hemorrhoids



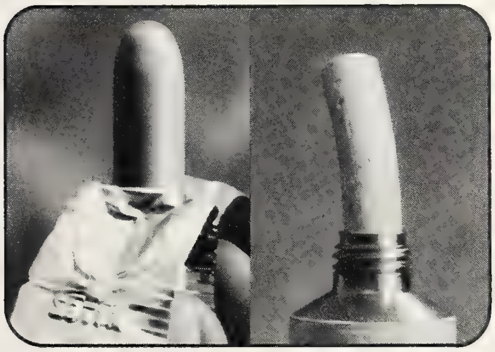
Internal hemorrhoids

Pruritus ani



Proctitis

Anal fissures



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Easy to apply,
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Prescribe Anusol-HC®

Suppositories/Cream

for symptomatic relief

- Effectively reduces inflammation and edema
- Rapidly relieves pain and itching

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

CAUTION: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2 25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%, Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients bismuth subiodide, calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22 5 mg; bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg, also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants

Anusol-HC is not for ophthalmic use

Dosage and Administration: Anusol-HC Suppositories—Adults. Remove foil wrapper and insert suppository into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment

NOTE If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24), in silver foil strips with Anusol-HC W/C printed in black

Anusol-HC Cream—one-ounce tube (N 0047-0090-01), with plastic applicator, detachable label

Store between 15°-30° C (59°-86° F.)

Full information is available on request.

W|C **Warner/Chilcott**
Division, Warner-Lambert Company
Morris Plains, N.J. 07950

AN-GP-91

The professional source of anorectal comfort

House Bills

HB 4028	Defebaugh	Liability for Tortious Acts for Employees of State Facilities	Did Not Pass
HB 4070	Hood	PHSRP	P. A. No. 368, 1978
HB 4110	Geake	Fifth Pathway Fund	Did Not Pass
HB 4135	Padden	One-Day Trial Duty	P. A. No. 11, 1978
HB 4163	DeStigter	1977-78 Appropriations for Dept. of Social Services	P. A. No. 105, 1977
HB 4215	Bryant	Limit of Malpractice Awards	Did Not Pass
HB 4263	Nash	Litigation Fees	Did Not Pass
HB 4340	R. Hood	Medical Practice Board Hearing Procedures	P. A. No. 23, 1977
HB 4420	Geerlings	Dentists/Death Certificates	Did Not Pass
HB 4425	Collins	Sex Education in Schools	P. A. No. 226, 1977
HB 4439	Symons	Definition of Death	Did Not Pass
HB 4491	Kehres	Reduction of Hospital Beds	Incorporated with Public Health Code, P. A. No. 368
HB 4515	Stevens	Definition of Malpractice	P. A. No. 272, 1977
HB 4549	Engler	Waiver of CME Requirements	Did Not Pass
HB 4633	Trim	Single Business Tax	Did Not Pass
HB 4902	McNeely	Extension of Brown-McNeely Fund	P. A. No. 42, 1977
HB 4903	Kelsey	Laetrile Therapy	Passed House/Failed Senate
HB 4913-17	Trim	Laetrile Therapy	Passed House/Failed Senate
HB 4918	Angel	Arbitration of Malpractice	Did Not Pass
HB 4919	Angel	Limits on Malpractice Awards by Insurance Commission	Did Not Pass
HB 4920	Angel	Prevents Disclosure of Liability Coverage	Did Not Pass
HB 4936	R. Hood	Three-year CME Requirements	P. A. No. 123, 1977
HB 5433	Symons	Exclusive Remedy & Compensation for Malpractice	Did Not Pass
HB 5450	Bullard	BC/BSM Election Procedure	Did Not Pass
HB 5477	Law	Determination of Licensure in Another State	Did Not Pass
HB 5578	McCollough	Eyes, Permits Removal, Under Certain Conditions/ (Anat. Gift)	Did Not Pass
HB 5747	Ryan	Interim Approval for Physician Assistants	P. A. No. 297, 1977
HB 5778	Hollister	Death & Dying Definition Medical Treat. Decision Act	Did Not Pass
HB 5963-68	M. Brown	Confidentiality of Medical Records	Did Not Pass
HB 6049	DeStigter/ Larsen	Department of Social Services Appropriations, 1978-79	P. A. No. 401, with line item veto 1978
HB 6424	Defebaugh	Uniform Anatomical Gift Act (Amends)	Did Not Pass
HB 6425	Defebaugh	Uniform Anatomical Gift Act (Amends)	Did Not Pass
HB 6557	Brotherton	Set Tuition Standards for Medical Students	Did Not Pass
HB 6575	Bullard	Medical Rights of Minors	Did Not Pass

Northern Michigan state and county mental care unified

Integration of Michigan's state and county mental health services is underway. Most recently state facilities and county mental health programs agreed to unify services within the northern Michigan region.

Participating in the formal signing procedures Dec. 21 were the Traverse City Regional Psychiatric Hospital, Alpine Center, the Department of Mental Health northern regional office, and representatives from the region's seven community mental health boards.

Separate documents were signed with the Traverse City hospital which serves psychiatric patients and Alpine Center, Gaylord, which services developmentally disabled persons.

This is the first time such agreements have been reached on a regional basis, according to V. A. Stehman, MD, acting director of the Michigan Department of Mental Health. Integration of state and local services, he said, is essential to the continuity of treatment programs from pre-admission to aftercare support services.

Pregnancy care posters available

Striking red, white and blue standup posters urging pregnant women to see their physicians before getting an X-ray or prescription are available without charge to physicians who wish them in single copy or multiples of not more than five (5).

The posters may be ordered from Diane M. Place, Consumer Affairs Officer, Detroit District Food and Drug Administration, 1560 East Jefferson Ave., Detroit 48207.

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FINANCIAL CORPORATION
10880 Wilshire Blvd
Los Angeles, CA 90024

MSMS leaders pay tribute to Herbert Auer, long-time MSMS staffer

Herbert A. Auer was MSMS deputy director until Jan. 2 when he left MSMS to become executive vice president of the Michigan Health Council. Mr. Auer had been with MSMS for 19 years and had responsibilities for continuing medical education and public service. He served as executive editor of *Michigan Medicine*.

By Louis E. Heideman, MD
MSMS President

Dear Herb,

Just a note to wish you well as you continue your career in a new setting. Your wisdom, humaneness, administrative sense, and general knowledge should be of great value in your position of executive vice president of the Michigan Health Council. I am especially pleased that the proximity of the two organizations is such that we can count on you for some guidance in your areas of special expertise from time to time. And the interests of MSMS and of Michigan Health Council are congruent enough that there will be many occasions when we can work together in service to the people of Michigan.

I must confess when I first heard of your imminent change I was quite upset, wondering how in the world we could ever fill the hole. But in addition to doing an excellent job in your own specific spheres of responsibility, you selected effective subordinates and then trained them very well. None of them individually or collectively can fill your shoes, but they can keep us moving forward. Thank you for your contribution in this area.

Again, my personal best wishes and those of the Society are with you in your new work.

By Louis R. Zako, MD
MSMS Council Chairman

Herb Auer's contributions to MSMS over the past 19 years are immeasurable.

He has done an excellent job as deputy director and as manager of the MSMS Division of Public Service, Communications and Physicians Education. Evidence of that division's excellence is demonstrated in one of the most successful scientific meetings in the nation, by the awarding of first place in national competition for editorial and design excellence to *Michigan Medicine*, and by well-received television and radio programs such as the Detroit-area's "Housecall."

Herb's value to the medical society goes far beyond his leadership in the management of this major division. Herb Auer perhaps more than any other person knows and understands the physicians of Michigan.

Herb's resignation is at the same time a major loss to MSMS and to me and a source of pride in his being selected to direct a sister organization, the Michigan Health Council. I think it is highly significant that Herb did not actively solicit his new position, but was offered it after the selection committee interviewed approximately 50 applicants for the job.

We all wish Herb success in this exciting new challenge.

By J. H. Tisdel, MD, Chairman
MSMS Committee on Publication

I have had the privilege of being involved with Herb Auer on a professional basis since he first joined MSMS in 1959.

For the past five years, we have developed a close relationship as I served as chairman of the Committee on Publications and helped guide the changes to the "new" *Michigan Medicine*.

I have known him as a thoroughly prepared professional who always did his homework and was well prepared with background information. I have watched him continuously present ideas and alternatives to solve problems. And, throughout, he has been loyal to medicine.

His obvious desire to reach all the MSMS membership and to involve as many as possible in MSMS activities prevailed at all times.

I regard his moving from MSMS to assume new duties with the Michigan Health Council as the personal loss of a loyal, hardworking man who made my work enjoyable and easy for me.

MSMS' loss is the Michigan Health Council's gain. I know he will do an excellent job for the health council, and he will be greatly missed here.

By Warren F. Tryloff
MSMS director

The ultimate objective of each association staff member is to head one's own association — to be the chief appointed executive, wholly responsible for implementing the policy directions of a board.

I'm glad Herb Auer has that opportunity. He deserves it and he'll do a fine job.

The MSMS management policy is a firm commitment to provide upward mobility for its staff. But it hurts many times to have someone as essential as Herb leave for new challenges.

Herb cannot be replaced. He is irreplaceable. Yet he has trained his staff well and his departmental functions will carry on. We are fortunate Herb is still in East Lansing and has agreed to serve MSMS in an advisory role in physician education.

His departure is a loss to MSMS and to me personally, for he has been friend, advisor, confidant and loyal coworker for nearly 20 years. I look forward to a new and different Michigan Health Council and to the success and happiness of Herb Auer.

Herbert A. Auer

MPMLC Clipsheet

Here's what your MPMLC coverage costs, offers and means to you

The MPMLC policy is written on an "occurrence" basis. With occurrence coverage, a physician pays now for a policy protecting against future claims arising from current professional services rendered. The occurrence policy covers a malpractice incident which *occurs* during the policy year, regardless of when a claim is filed, even if it is years in the future.

Limits

Two sets of limits are offered:

$100,000 per occurrence/$300,000 annual aggregate
$200,000 per occurrence/$600,000 annual aggregate

What the Policy Covers

The physician is placed in a rating classification based on specialty, procedures performed, and geographical location of practice, using information ascertained from a detailed initial application.

Once the proper classification is determined and a policy issued, coverage is on an "all risk" basis. The physician's *entire* medical practice is covered, excepting only those circumstances which are specifically excluded by the policy or endorsements to the policy. Beyond those exclusions, only fraud in obtaining the insurance, such as lying on the application, would be cause for MPMLC to deny coverage.

Underwriting

Most policies are issued promptly following a review by the underwriting department. Any application considered questionable is referred for peer review by the MPMLC underwriting committee, composed of three allopathic and two osteopathic physicians.

Policy Ownership

An insured physician "owns" the policy bearing his/her name. Only that physician may authorize MPMLC to alter the coverage in any way. For example, only the insured may request cancellation of the policy, even if the policy premium is paid by an individual or organization other than the insured physician.

Coverage Options

Under certain circumstances, a 50 percent premium reduction is allowed for physicians in part-time practice, semi-retired physicians, and physicians in their first year of practice. A specially endorsed policy may also be purchased to provide coverage for a physician's emergency room work only or to exclude coverage of emergency room work. Locum tenens coverage may also be obtained.

A corporate or partnership coverage endorsement is offered to a group practice when all group members are MPMLC insureds. The premium of each physician in the group is increased by 10 percent to compensate MPMLC for this additional exposure.

Applicability and cost of these options may be determined by contacting MPMLC.

Additional Charges and Surcharges

Additional charges are added to the base premium to reflect exposure created by employed physicians, physicians' assistants, and technicians. These charges do

Here is the third in a series of articles intended to better inform Michigan doctors about the Michigan Physicians Mutual Liability Company and its activities. Additional information may be obtained by contacting MPMLC at PO Box 1471, East Lansing, 48823; 800/292-1460 (toll free) or 517/351-1150.

MPMLC/*continued*

not provide the employee with coverage, they merely alter the physician's premium to account for total exposure.

Surcharges may be applied based upon a physician's professional history.

Premium Payment

Premium is billed when the policy is issued. If over $2,000, a quarterly or semi-annual financing plan may be arranged by contacting MPMLC for details.

Policy Renewal

As the policy renewal date approaches, MPMLC asks the insured physician to detail any changes which may have occurred since the initial application. Periodically, MPMLC will require the completion of a shortened renewal application to develop statistical information beneficial to the program. Nonrenewal of policies by MPMLC is subject to the same peer review process used in initial underwriting.

Policy Cancellation

Any policy cancellation initiated by MPMLC is done on a pro-rata premium basis. When cancellation is initiated by the insured, premium is calculated using a short rate cancellation table which is standard in the insurance industry. Use of the short rate compensates for the fact that administrative effort expended is equal for short term and full year policies.

It should be noted, however, that pro-rata premium is applied when a short term policy is issued to secure a common policy date with other insureds, as in a group practice.

Appeal

A physician who wishes to appeal declination, cancellation, or application of a surcharge, may do so either in writing or by a personal appearance before the underwriting committee.

Tenuate® Ⓒ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A

Licensor of Merrell®

References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

B-3921 (Y5B7A)

Whether overweight is a complicating factor... or just uncomplicated overweight.

Tenuate® Dospan® ©IV
(diethylpropion hydrochloride NF)
75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

Merrell

For prescribing information see opposite page.

The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions. However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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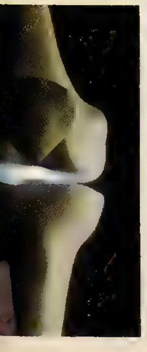
RHEUMATOLOG



Motrin 400 TABLETS mg
ibuprofen, Upjohn

The confidence that comes from experience—
one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

J-6857 4

The confidence that comes from experience—
one more reason to prescribe

Motrin 400 mg TABLETS
ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.
Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.
Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)	
Bottles of 60	NDC 0009-0733-01
Bottles of 500	NDC 0009-0733-02
Motrin Tablets, 400 mg (orange)	
Bottles of 60	NDC 0009-0750-01
Bottles of 500	NDC 0009-0750-02
Unit-dose package of 100	NDC 0009-0750-06
Unit of Use bottles of 120	NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

NIM-3

Upjohn
The Upjohn Company
Kalamazoo, Michigan 49001

ALDOMET®
(METHYLDOPA|MSD)
TABLETS: 500 mg, 250 mg, and 125 mg

MSD
MERCK
SHARP &
DOHME

Category I courses

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Feb. 15, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 19-23, Emergency Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians, internists, emergency physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 36½ hours of Category I Credit.

Date: Feb. 24-25, Rheumatology Seminar for the Practicing Physician. Location: Gordon H. Scott Hall, 540 E. Canfield, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine. **For:** Family physicians, internists, physicians involved in management of rheumatic diseases. **Cost:** $65. **Contact:** Wayne State University School of Medicine, Div. of Continuing Medical Education, 1206 Scott Hall, Detroit 48201, 313/577-1180. **Approved for:** 9 hours of Category I Credit.

Date: Feb. 27-28, Topics in Psychosomatic and Behavioral Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Psychiatrists, primary care physicians. **Cost:** $120. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Feb. 28-March 1, Michigan Conference on Maternal and Perinatal Health. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Katie Brewbaker, MSMS, 517/337-1351. **Approved for:** 14 hours of Category I Credit.

Date: March 1-3, Workshop in Advanced Cardiac Life Support. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $175. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 20 hours of Category I Credit.

Date: March 6, Symposium on Recent Advances in Cancer Care. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** The Grand Rapids Clinical Oncology Program. **For:** Physicians interested in optimal cancer care. **Cost:** $30. **Contact:** The Grand Rapids Clinical Oncology Program Office, 616/774-1230. 100 Michigan N.E., Grand Rapids 49503. **Approved for:** 9 hours of Category I Credit.

Date: March 6-9, Hematology Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Hematologists. **Cost:** $225. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 28 hours of Category I Credit.

Date: March 11-16, Boyne Mountain Mid-winter Cancer Symposium. Location: Boyne Mountain, Boyne Falls. **Sponsor:** Wayne State University School of Medicine, Dept. of Oncology. **For:** General practitioners, family practitioners, surgeons, radiotherapists, pathologists and oncologists. **Cost:** $175. **Contact:** Div. of Continuing Medical Education, Wayne State University School of Medicine, 1206 Scott Hall, 540 E. Canfield, Detroit, 313/577-1180. **Approved for:** 29 hours of Category I Credit.

Date: March 14, Kidney Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: March 14-16, Advances in Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians. **Cost:** $180. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: March 21, Detection and Primary Care of Breast Cancer. Location: Kalamazoo Hilton Inn. **Sponsor:** Oncology Sections, Borgess and Bronson Hospitals, Kalamazoo. **Cost:** $50 in advance, or $60 on the registration day. **Contact:** C. L. Zeller, Jr., MD, Southwestern Michigan Health Education Center, 252 East Lovell St., Kalamazoo 49007. 616/383-6489. **Approved for:** 7 hours of Category I Credit.

Date: March 21, Early Breast Cancer. Location: Kalamazoo Center Inn, Kalamazoo. **Sponsor:** Bronson and Borgess Hospitals Oncology Section. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All Interested Physicians. **Cost** $50. **Contact:** Leo Zelkowitz, MD, Bronson Hospital, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: March 22-23, General Surgery. Location: Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Surgeons. **Cost:** $145. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 15 hours of Category I Credit.

Date: March 23-24, XII Annual Cancer Symposium. Location: Green Auditorium, 3rd Floor Scott Hall, Wayne State University School of Medicine Campus. **Sponsor:** Wayne State University School of Medicine, Dept. of Oncology. **For:** General practitioners, surgeons, radiotherapists, pathologists and oncologists. **Cost:** $75. **Contact:** Div. of Continuing Medical Education, Wayne State University School of Medicine, 1206 Scott Hall, 540 E. Canfield, Detroit, 313/577-1180. **Approved for:** 9.5 hours of Category I Credit.

Date: March 24, A Day of Clinical Gastroenterology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Family physicians, internists. **Cost:** $70. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: March 28-30, Staff Development: A Team Approach in Treatment Settings. Location: U-M, Ann Arbor. **Sponsor:** Institute of Gerontology, U-M/WSU. **Cost:** $95. **Contact:** Dorothy Coons, Continuing Education Program, Box N, Institute of Gerontology, 520 E. Liberty, Ann Arbor 48109. 313/764-3493. **Approved for:** 16 hours of Category I Credit.

Date: March 30, Brain, Lung, and Trauma. Location: Kalamazoo Valley Community College. **Sponsor:** Bronson Methodist Hospital. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Emergency room physicians, neurosurgeons, pulmonary medicine specialists, family physicians. **Cost:** $30. **Contact:** Educational Services, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo 49006. Phone: 616/383-6405. **Approved for:** 7 hours of Category I Credit.

Date: April 2-27, Surgical Anatomical Review. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Surgeons. **Cost:** $425. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 120 hours of Category I Credit.

Date: April 6-7, Medical and Surgical Problems in Infants, Children and Adolescents. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $150. **Contact:** Henry Ford Hospital, Office of Medical Education, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 15 hours of Category I Credit.

Date: April 12, Conference on Medical Aspects of Sports. Location: Towsley Center, Ann Arbor. **Sponsor:** MSMS. **Contact:** Mert Scholten, MSMS, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME. 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: April 16-June 18, Pediatric Seminar IV. Location: St. John Hospital Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $200. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 20 hours of Category I Credit.

Date: April 19, 20, 1979, Michigan Chapter American College of Surgeons. Location: Ann Arbor, Rackham Building. **Sponsor:** University of Michigan Medical Center. **For:** Surgeons. **Cost:** No charge. **Contact:** John H. McLaughlin, MD, 604 N. Woodward, Birmingham, Michigan. **Approved for:** 12 hours of Category I Credit.

Date: April 23-27, Cardiology Tutorial Program. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital, Office of Continuing Education. **For:** General practitioners and internists. **Cost:** $300. **Contact:** Sidney Goldstein, MD, Div. of Cardiovascular Medicine, 313/876-2727. **Approved for:** 40 hours of Category I Credit.

Date: April 24, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:**

MSMS, AMA, MSMS/A and medical assistants

Feb. 15 — Michigan Ophthalmological Society, Wayne County Medical Society headquarters, contact: Helen Schulte, MSMS headquarters.

Feb. 20-21 — MSMS Practice Management Workshop, "Establishing Yourself in Private Practice," Lansing, for residents, contact: John Richards, MSMS headquarters.

Feb. 22-23 — MSMS Practice Management Workshop, "Establishing Yourself in Private Practice," Detroit, for residents, contact: John Richards, MSMS headquarters.

Feb. 28-March 1 — MSMS Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

March 4 — Medical Assistants Board Meeting, MSMS headquarters, contact: Helen Schulte, MSMS headquarters.

March 7 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 15 — Michigan Ophthalmological Society, Frankenmuth, contact: Helen Schulte, MSMS headquarters.

April 10 — MSMS Auxiliary Legislative Day, Kellogg Center, East Lansing, contact: Helen Schulte, MSMS headquarters.

April 12 — MSMS Conference on Medical Aspects of Organized Athletics, Towsley Center, Ann Arbor, contact: Mert Scholten, MSMS headquarters.

April 26-29 — Medical Assistants State Convention, Lansing, contact: Helen Schulte, MSMS headquarters.

May 4-6 — MSMS Auxiliary Annual Convention, Sheraton Inn, Kalamazoo, contact: Helen Schulte, MSMS headquarters.

May 4-5-6 — MSMS House of Delegates, Kalamazoo Center Inn, Kalamazoo, contact: Richard Campau, MSMS headquarters.

July 5-8 — MSMS Council, Birchwood Farm Golf & Country Club, Harbor Springs, contact: Warren Tryloff, MSMS headquarters.

July 22-26 — AMA Annual Meeting, Chicago Marriott Hotel, contact: AMA headquarters, 312/751-6000.

Sept. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters, 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other Meetings

March 22-23 — Program on Hospital Accreditation Standards (PHAS), Bellaire, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing 48912. 517/484-7441.

June 15-19 — Association for Behavior Analysis 5th Annual Convention, Hyatt Regency Dearborn, contact: ABA Program Committee, Dept. of Psychology, Western Michigan University, Kalamazoo 49008, 616/383-1629.

CATEGORY I/*continued*

Pathologists. **Cost:** $25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: April 28, Decision Making in Difficult Cardiac Patients. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $70. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: May 5, Spring Northern Michigan Perinatal Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Northern Michigan Hospitals, Inc., Petoskey. **For:** Pediatricians, obstetricians, family practitioners. **Cost:** $30. **Contact:** Rochelle Igrisan, RN, Perinatal Nurse-Educator, Northern Michigan Hospitals, Inc., Petoskey 49770, 616/374-7373 or 616/347-5000. **Approved for:** 6 hours of Category I Credit.

Date: May 8, Human Values and Health Care. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **Cost:** $50. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: May 10-11, Ophthalmology Conference. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: May 12, Michigan Society of Pathologists May Seminar, "Mucosal Biopsy of the Gastrointestinal Tract." Location: Hurley Hospital, Flint. **Sponsor:** Mt. Carmel Mercy Hospital, Dept. of Pathology. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit, MI. **Approved for:** 3 hours of Category I Credit.

Date: May 14-18, Head and Neck Oncology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otorhinolaryngologists, surgeons. **Cost:** $500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: May 18, Infectious Diseases Symposium. Location: Grand Rapids. **Sponsor:** Butterworth Hospital, Grand Rapids. **Contact:** Butterworth Hospital Medical Education Office, 616/774-1835. **Approved for:** 7 hours of Category I Credit.

Date: May 21-25, Advances in Internal Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Internists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

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MSU School of Osteopathic Medicine committed to quality work, programs

By Myron S. Magen, DO
East Lansing

Prominent in the present and future of the osteopathic profession is its shift from private to public education, a movement spearheaded by the establishment of a college of osteopathic medicine at Michigan State University in 1969.

During the decade that has followed, enrollments have burgeoned, the profession has blossomed, and osteopathic educators have had to face new stresses endemic to partnership with the academic community.

The MSU College of Osteopathic Medicine was the first new osteopathic school founded in the United States in more than 50 years, and was the first to be university-affiliated and state-supported.

Since its inception, six other colleges of osteopathic medicine — five of them public institutions — have been started in Texas, Oklahoma, West Virginia, Ohio, New York and New Jersey. Two other schools, one in New England and one in California, have received preaccreditation status from the American Osteopathic Association.

Geometric increase

Enrollment in osteopathic colleges has increased geometrically, from 1,879 students in 1969 to 4,284 in 1978. The increase in enrollments of 7.4 percent during the last year alone parallels government labor forecasts that osteopathic medicine is among the 26 professions with the best employment opportunities for early 1980s graduates.

With more than 17,000 DOs currently in practice, graduates from osteopathic medical colleges will exceed 1,000 during 1979.

We at the MSU College of Osteopathic Medicine have been proud of our role in the support and establishment of these younger colleges, for the training of a cadre of physician/academicians has been a consistent goal of our work. Though our primary commitment, and that of all colleges of osteopathic medicine, remains the training of competent family physicians, we at MSU have felt an obligation to utilize the unique resources of the university to bring the osteopathic profession more fully into the mainstream of the academic tradition.

Thus top administrators for three of the new colleges have come directly from MSU: John Barson, DO, president of the Oklahoma College of Osteopathic Medicine and Surgery; Ralph Willard, DO, dean of the Texas College of Osteopathic Medicine, and Gerald Faverman, DO, former acting dean of the Ohio College of Osteopathic Medicine.

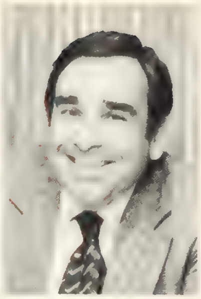
Schizophrenic situation

However, the existence of colleges of osteopathic medicine on the campuses of major universities causes the same kind of schizophrenic situation that faces the MD schools. How do we maintain our commitment to the people of our state to produce physicians both competent and willing to practice at the community level, and at the same time carry out our commitment to function according to the expectations of the academic community? The value system for each is entirely different.

The most important job facing both professions may be to place ourselves appropriately between the two extremes.

Golden mean

To find that golden mean, we at the Michigan State University College of Osteopathic Medicine are committed to the fulfillment of three missions: the mission of preparing highly competent primary care physicians for service in the state, the mission of research basic to understanding the influence of the musculoskeletal system in health and disease, and the mission of preparing a cadre of well-trained academicians and scholars for the teaching and research of osteopathic principles.


Dean Magen

To meet our commitment to family practice, we select students with the desire to be family physicians, emphasize its importance in our didactic courses, and provide clinical training in community hospitals and ambulatory care centers throughout the state.

Research goals are addressed on many fronts. Our Department of Biomechanics was established expressly to find quantifiable data relevant to the relationship of structure and function in disease. Faculty in the College's Carcinogenesis Laboratory hold millions of dollars in public and private grants and are known world-wide for their research on environmentally-induced cancers. In addition, other significant medical research — ranging from endocrinology to investigations of nerve function — is conducted by faculty in basic science and clinical departments administered by the College.

Faculty development programs have been established at MSU to meet the need created by the nine new colleges of osteopathic medicine for competent DO academicians. These programs range from seminars on educational techniques for practicing physicians who wish to teach, to joint DO-PhD programs which emphasize the need for the triad of medical, research and educational skills for the osteopathic faculty member.

There is no doubt that the osteopathic profession has benefitted greatly from its relationship with the traditional academic community. Ensuring the continuing success of the profession, however, will take an enduring commitment to quality in medical service, in research, and in medical education.

Doctor Magen is dean of the Michigan State University College of Osteopathic Medicine.

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Views

Physicians must use opportunities to affect state health plan's impact

By Ernest M. Hammel, PhD
Rochester

On the basis of national data from HEW and the National Institute of Medicine, the authors of Michigan's preliminary state health plan assume that Michigan's physician supply is at or near surplus levels. They predict that by 1990 our state will have a natural increase of 7,400 physicians while the proportion of primary care physicians will be reduced to 39.3 percent of the physician population. These predictions are among those key to medical groups in the preliminary Michigan state health plan required by the National Health Planning and Resource Development Act.

The preliminary plan has been approved by the Statewide Health Coordinating Committee after modification reflecting the concerns of many health-related organizations, including MSMS. The plan now goes to the legislature and to the governor for further approval.

The plan is designed to be the principle guide for development of state health programs and for allocation of resources to health activities in the state. A new plan is to be prepared annually.

On the basis of their assumption about physician supply, the Michigan plan's authors propose the total supply of clinically active physicians should remain at or near 1977 levels and the proportion of primary care physicians should be increased to 60 percent. Their objectives are to achieve by 1983 a maximum ratio of 130 physicians per 100,000 population, and a ratio of primary care physicians to population of at least 1:3,500.

Doctor Hammel is the Executive Director of the Oakland Health Education Program, an area health education center in Oakland County.

There are differing opinions, of course, regarding the existence of a physician surplus and the need to stop training physicians at the present rate. In his address to the 1978 Congress on Medical Education, C. H. William Ruhe, MD, pointed out that there still are shortages of primary care and highly specialized services. On the basis of current evidence, he predicted a greater demand for services in the future, while new regulations governing admission of foreign medical graduates to the country may slow the growth rate of the physician population. Until the outcome of such issues is reliably determined, some caution should be exercised in estimating the adequacy of the physician supply.

To extrapolate from national data is to assume that the Michigan physician population is typical of the aggregate. On the contrary, it is known that Michigan's population of foreign medical graduates is significantly larger than the national aggregate and the proportion of primary care physicians is higher.

There is also some question as to whether or not the authors of the plan considered factors which contribute to attrition of the physician population. These include a shrinking pool of medical school candidates, career changes into nonpractice activities, and retirement.

Finally, it is misleading to project manpower levels in terms of physician-population ratios. These ratios are, at best, "guesstimates" which may vary from actual need. It is not so much that the overall and primary care ratios projected in the plan are unreasonable but rather that they may be achieved without adequate services being available to the residents of Michigan. This is illustrated by the 49 rural and urban physician shortage areas identified in the state.

Thus, in considering these additional factors, one should pause to question whether the assumptions in the plan and the resulting goals will lead to solution or to aggravation of physician resource problems.

Planning for primary care

The need for more primary care physicians in Michigan is well known. According to the data cited in the plan, 47 percent of Michigan's clinically active physicians practice in primary care specialties. In order to increase the proportion of primary care practitioners to 60 percent, the plan proposes to increase the number of primary care training positions by 15 percent by 1983, to emphasize primary care practice to medical students in Michigan schools and to increase financial incentives for primary care physicians.

In considering these assumptions, it should be noted that the proportion of primary care physicians and the ratio of physicians to population are derived from health maintenance organization (HMO) data. HMOs, however, usually serve atypical populations, use only a portion of the array of physician specialties which exist in the usual practice community and offer a finite range of services. Thus, outside the insular HMO setting, different configurations of primary care resources may be more appropriate.

Extraordinary emphasis on primary care education may raise some serious organizational and economic questions. At the same time that medical schools and teaching hospitals train primary care physicians, the complexities of modern medicine and the standards for primary care education require they maintain a balance between primary and nonprimary care programs and not lose their capacity to train in other specialties. Curtailment of programs to 1977 levels, coupled with an increase of primary care programs, will

(Continued on page 90)

Physicians' will to update selves key to CME programs

One of the most provocative speeches at the 1978 AMA Conference re CME in Chicago was given by Melvin D. Small, MD, chairman of the Medical Society of Virginia's Commission on Continuing Medical Education.

He voiced four concerns: "(1) that there be a more even-handed accreditation effected through the maximal utilization of the trained cadre of experts on the state committees or commissions of continuing education who are better able to assess the nuances based on their survey, (2) that standards for advertising be promulgated, (3) that further efforts be directed to the inclusion of the needs of practicing physicians in the formulation of policy and the creation of programs, and (4) most importantly, that we must investigate methods of continuing medical education to assess their effect, if any, on improving health care delivery."

Doctor Small offered four observations to improve the present situation: "(1) that the uneven accreditation of programs has created animosity among our friends, (2) that the titillating packages of tours of continuing education have created a target for our enemies, (3) that we must receive a mandate for continuing education from the practicing physician, and (4) that we must investigate methods of continuing education to assess their value, if any, in improving health care delivery."

Doctor Small also said, "I must add one note in closing, and that is that the most important factor in continuing education is not the tightness of the accreditation guidelines but the motivation of the practicing physician to update his skills; and this cannot be achieved by a mandate from above, by imposed requirements, or by recertification exams as they now exist. It must emanate from a healthy, demanding patient/physician relationship and from the obsessive/compulsive nature of most of our confreres."

(Editor's note: MSMS members are invited to send their "viewpoints" to Michigan Medicine *about the mandatory CME law in Michigan and/or about the CME offerings and problems in Michigan. Send them to Managing Editor,* Michigan Medicine, *120 West Saginaw, East Lansing, 48823.)*

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result in losing the ability to maintain this balance.

Redistributing financial incentives in the medical community might result in an abrupt escalation of health care costs rather than a redistribution of existing dollars. Many primary care physicians are highly productive and, therefore, highly utilized. Reimbursement of this comparatively high volume of service at high rates will require allocation of additional dollars to health care.

Limiting medical school enrollment

One of the policies for stabilizing the total number of physicians calls for limiting first-year medical student enrollment. For all schools together, first-year enrollment would be limited to 745 students per year.

Fixing medical school production at these levels may aggravate future physician shortages because 56.8 percent of these graduates leave the state to train and practice elsewhere. The plan does not seem to consider this rate of loss and offers no assurance that the number who stay will be equal to the natural attrition rate in the physican population.

Another facet of this problem concerns the 2,755 medical graduates who were enrolled in Michigan residency programs in 1976. Of the total, 866 were graduates of Michigan schools, 842 were graduates of other states and 1,032 were FMGs. In addition to poor retention of Michigan graduates, this distribution illustrates Michigan's dependency on FMGs. In order to compensate for curtailment of the FMG supply, it will be necessary to maintain undergraduate training capabilities, to improve retention of Michigan graduates and actively recruit graduates from other states. Strategies to accomplish this are absent from the plan.

Changing residency training resources

Originally, the plan's authors proposed holding residency positions available in Michigan hospitals to the number available in 1977. In order to deal with geographic maldistribution, they also recommended the number of positions in primary care programs located outside of Southeastern Michigan should be increased and rural area health education centers (AHECs) should be started. The modified plan calls for such decisions to be handled by a proposed graduate medical education system.

Fixing residency positions at 1977 levels may be an inappropriate way to meet future needs for training resources. This policy may limit the ability of teaching hospitals to adapt to changing conditions in the health care environment.

While studies have shown practices concentrate near training centers, the proposed strategies of disbursing residencies across the state and creating rural AHECs oversimplifies the problem. They do not take into consideration the need for critical mass (population base, adequate faculty and teaching resources) and the need to meet accreditation requirements specified by the Liaison Committee on Graduate Medical Education. The key to solving maldistribution problems is not the costly disbursement of residencies. It is the establishment of a professional consultation and support network which will provide the physician with ready access to existing training centers.

Opportunities for effective planning decisions

Effective planning is characterized by generation of valid assumptions; selection of realistic, appropriate courses of action which best use resources and development of cogent implementation strategies. In order to accomplish this, several basic needs must be fulfilled:

1. Every effort must be made to secure reliable, complete information about Michigan's physician population.

2. Technical problems must not be confounded with political problems. While it is necessary to seek solutions which are acceptable to the people of Michigan, the need to provide the community with technically competent alternatives must not be overlooked. Improving technical input depends upon an active dialogue with the medical community.

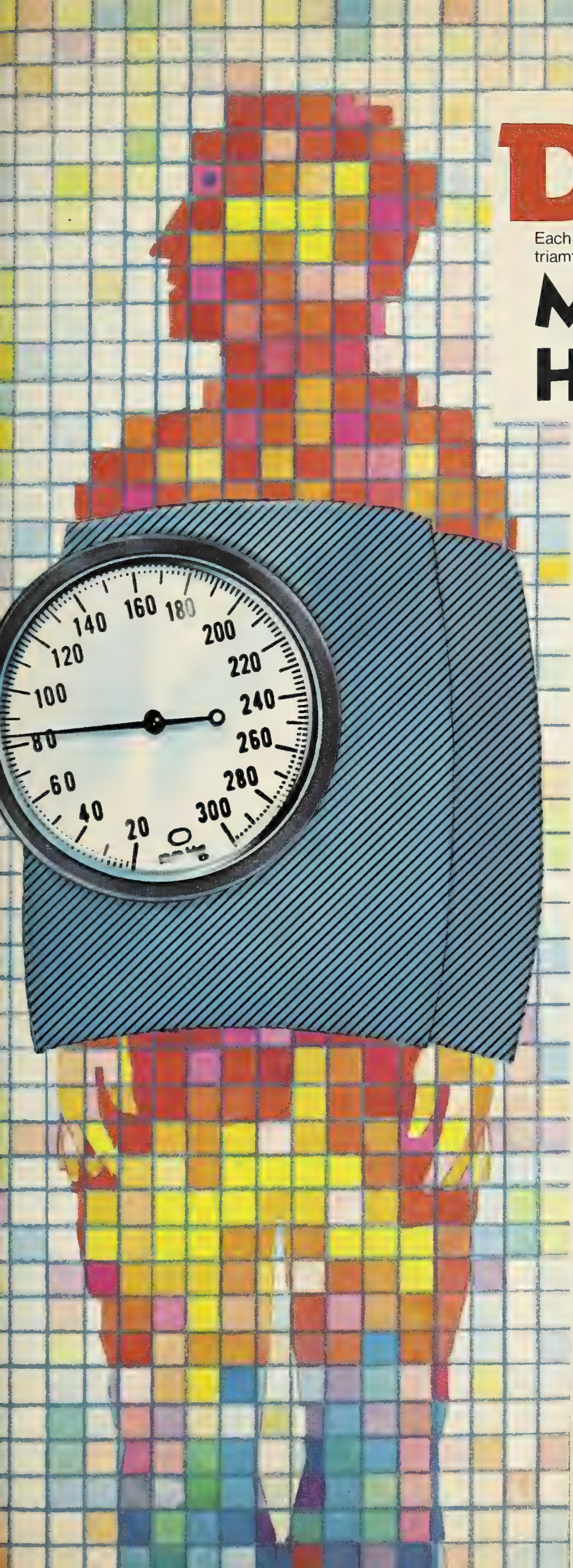
3. We must select policies and courses of action which are appropriate to the problem and practical from the standpoint of available technology resources.

The need for participation in planning

Although planning is a rational systematic process, it exists in a political environment. When organizations and individuals perceive that planning decisions may affect them, they often seek to influence the identification of problems and the selection of solutions. This political input sometimes reduces the objectivity of the planning process. More often, however, it produces a greater variety of acceptable solutions.

The Michigan Health Plan will be continually revised. This offers opportunities for the medical community to participate in the planning process and contribute needed technical information. Continued impact on health planning will require that physicians make a permanent investment in both the state and areawide planning processes.

(References are available from the author.)



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Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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When painful spasm is the presenting symptom . . .

. in functional G.I. disorders*

Bentyl®

(dicyclomine hydrochloride USP)

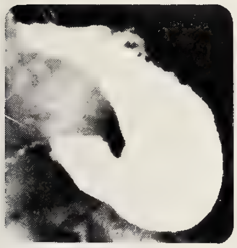
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

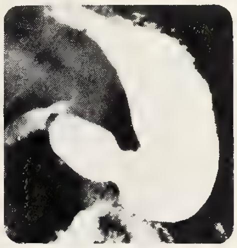
Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

---

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-3497 (Y515A)

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INDICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer
IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective.

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon)

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with autonomic neuropathy, hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension, hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur. ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia, palpitations, mydriasis, cycloplegia; increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness, dizziness, insomnia; nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs

Usual Dosage Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water) Bentyl 20 mg.. *Adults* 1 tablet three or four times daily Bentyl Injection *Adults* 2 ml (20 mg.) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used

Product Information as of October, 1976

Merrell

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Diversity MSMS' strength in making policy decisions such as abortion funding view

Some MSMS members have expressed their displeasure with the 1978 MSMS House of Delegates resolution to "support the practice of state funding of abortions for Medicaid patients."

In response, MSMS Speaker of the House James D. Fryfogle, MD, has sent the following letter. (We present excerpts here.)

"As I'm sure you are aware, the MSMS House of Delegates, as most other representative bodies, operates on the principle of majority rule. Those proposed resolutions which are able to garner sufficient votes become the policies of MSMS.

"The issue of abortion has been brought to the House of Delegates for discussion many times and it has always generated controversy.

"Policies on abortion have been adopted by the House of Delegates since 1968. Although the 1978 action by the House is contrary to the personal beliefs of a number of physicians, it does appear consistent with other policies regarding abortions which have been adopted by the majority in the past ten years."

One MSMS member stated that Resolution 78A-34 "compels each member of the State Medical Society, by his membership, to support the destruction of innocent human lives."

Replied Doctor Fryfogle, "I believe the intent of the House of Delegates was much more narrow and only spoke to the continued availability of reimbursement for abortion procedures performed by physicians who offer such medical services to their Medicaid patients.

"The intent of these policies on abortion in relation to an individual physician's practice was clearly stated in the House's 1968 and 1970 action which states:

'The MSMS respectfully recognizes that some physicians because of moral or religious grounds oppose liberalization of the abortion law. Therefore no physicians or hospital should be compelled directly or indirectly to perform a therapeutic abortion."

Doctor Fryfogle urged that member to reconsider his opposition. "Our strength is not only in our unity when faced by a common opponent," he said, "but in our diversity when attempting to make policy decisions internally."

MSMS congratulates Donald E. Johnson for award

(The following letter was sent recently from MSMS headquarters to Donald E. Johnson, Flint. Mr. Johnson was active some years ago with the Michigan Cancer Coordinating Committee.)

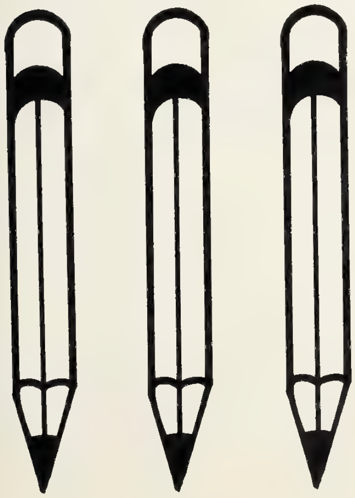
We have heard at MSMS the good news about the very high honor bestowed on you recently by the American Cancer Society.

Your friends, Doctor Hiscock and Bill Burns have each told us about this good news. They both recall your outstanding service to the medical profession and the people of Flint and Michigan over a long span of years. The "Cancer Day" programs at Flint were highly valued.

The younger doctors do not realize your great contributions. Many of them do not know that the Michigan State Medical Society awarded you a coveted "MSMS Honorary Membership."

Once again, we congratulate you as the recipient of the Distinguished Service Award of the American Cancer Society!

Warren F. Tryloff
MSMS Director



". . . thanks for . . . Educational Loan Fund."

(The following letter was forwarded to MSMS headquarters by Milli Fox of the WSU School of Medicine University Relations office.)

It is with sincere appreciation that I take the opportunity to express my thanks to those responsible for setting up the AMA Educational Loan Fund. I am the recipient of an emergency loan made possible through the generosity of your organization, without which life would have been much more hectic. I hope that in the future you will continue to support our program here at the Wayne State University School of Medicine by continuing the availability of loan funds. Thank you.

Robert C. Padilla, Year I
Wayne State University
School of Medicine

". . . interested in . . . desk reference cards."

I was quite impressed with the Maternal Health Desk Reference Card, No. 23, which appeared in the December, 1978, issue of *Michigan Medicine.*

I am interested in obtaining the complete set of desk reference cards.

I would appreciate any information that you could give me on how to go about doing this.

George G. Bruzza, Jr., MD
Kalamazoo

(Editor's note: Complete sets of the Maternal Health Desk Reference Cards, prepared by the MSMS Committee on Maternal and Perinatal Health, are available on request, free of charge, from Helen Schulte at MSMS headquarters, 517/337-1351.)

Comments on November Family Practice issue

Thank you for the current issue of *Michigan Medicine* featuring the special section on family practice.

Congratulations on a well conceived and executed effort.

I'm asking Mr. Bill DeLay, director of our communications division, to circulate copies of the section to our Board and other interested members.

Roger Tusken, Executive Director
American Academy of
Family Physicians

I was delighted with the November issue of *Michigan Medicine* and the job that you have done planning this issue. I singled this issue out at our last board of directors meeting of the Michigan Academy of Family Physicians on December 6, 1978. All present felt that this was a fine endeavor on your part.

Gary E. Ruoff, MD
Kalamazoo

Business

Physicians' employees could be affected by these federal, state laws and regulations

By R. Timothy Hogan, CPBC
Ann Arbor

Over the years, particularly since the civil rights battles of the 60's, a complex matrix of legislation has been enacted and regulations set in place at federal, state and local levels to protect employees' rights.

Failure to comply with these new laws and the regulations surrounding them can result in stiff payments to employees and civil and criminal fines and penalties on employers.

Most practitioners, already chafing at over-regulation of their practices and the growing paperwork required for compliance with the proliferation of regulations, would prefer to ignore some of these employment provisions. Some mistakenly assume they rarely apply to professional offices when the truth is they quite often do.

Employees themselves have not yet recognized the full significance of these new laws and few complaints have surfaced against professionals. But as more workers come to understand their employment rights, now established by law, professional offices will begin to feel their impact and problems will develop.

Generally, these new laws relate to wages and salaries, equal pay for equal work, child labor, equality of job opportunity, workmen's compensation, and guarantees of a safe working place. Here are brief summaries of various key statutes that could affect professionals' employees:

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

Fair Labor Standards Act (FLSA)

Administered by U. S. Department of Labor. Applies to employees engaged in interstate commerce activities and to businesses or professional offices with annual gross receipts exceeding $275,000. Certain categories of executive, professional and administrative personnel are exempted. Registered nurses, for example, if devoting 80 percent of their time in a professional office to nursing duties, are exempted; the same 80 percent provision extends to workers classified as executives or administrators. Most group practices are caught in the regulatory net by the gross receipts provision, but smaller professional offices come under the umbrella because the "interstate commerce" test can be applied to duties employees perform related to mail, telephone calls across state lines, insurance claims across state lines and so forth.

The Fair Labor Standards Act specifies minimum wages and salaries, sets provisions for overtime payment, requires a variety of record-keeping duties in connection with documenting hours worked and lays down rules related to hiring of minors. A 1977 amendment to the law provided that as of Jan. 1, 1978, the minimum hourly wage was $2.65. Automatic increases to $2.90 went into effect in January, and further increases to $3.10 in January, 1980, and to $3.35 in January, 1981 are required.

Most professionals already are paying their employees above the minimum wage. The real crunch will come later. Unless pay scales for skilled employees are adjusted upward as the minimum wage rises, the spread between these workers and the less-skilled workers will shrink, causing plenty of office management problems.

According to FLSA, every employee must be paid at the rate of 1½ times the regular pay rate for hours in a workweek worked in excess of the maximum hours applicable to the type of employment in which the employee is engaged. Traditionally accustomed to putting in long hours in professional pursuits, some practitioners have expected their employees to work overtime, often without extra pay. Now, except for exempted employees, that's no longer permissible.

To prevent child labor abuse, the FLSA stipulates that no persons under 16 can be employed in hazardous occupations or work during school hours. Regulations permit employment of 14 and 15-year-olds in certain jobs after school hours but only for a limited number of hours under specified conditions of employment.

Compliance with the Fair Labor laws requires specific record-keeping procedures. A professional office with covered employees should adopt a payroll system documenting hours and working benefits, consider using a time clock or time sheet to keep track of hours worked, and spell out in writing all employment policies.

Equal Pay Act of 1963

Administered by the U. S. Department of Labor. Applies to all employees subject to the provisions of the Fair Labor Standards Act, with the same exclusions of certain executive, administrative and professional workers.

Dating back to 1963, this law as amended prohibits any wage discrimination based on sex. An employer cannot discriminate by paying employees of one sex at rates lower than those paid to employees of the opposite sex in the same workplace for doing equal work on jobs requiring equal skill, effort and responsibility and performed under similar working conditions. Nor can an employer reduce the wage rate of any employee in order to eliminate a prohibited wage differential. Appropriate record-keeping is required for compliance.

Age Discrimination in Employment Act of 1978

Administered by the U. S. Department of Labor. Covers any enterprise with 20 employees or over $250,000 in sales.

This legislation protects workers between 40 and 70 from any job discrimination based on age. Discrimination cannot occur in hiring or firing, in setting compensation, terms, conditions or privileges of employment, retirement or in any way limiting such employees that would deprive them of employment opportunities or adversely affect employment status.

Civil Rights Act of 1964, Title VII

Enforced by Equal Employment Opportunity Commission (EEOC). Applies to all private employers of 15 or more persons.

This legislation prohibits job discrimination on the basis of race, color, religion, sex or national origin when hiring or firing, paying or employing an individual. The same restrictions with regard to terms and conditions of employment and provision of opportunities for advancement, specified in the Age Discrimination in Employment Act described previously apply here. However, it should be emphasized that this legislation does not mean that an employer must hire someone who cannot do the job.

The courts have upheld the various statutes relating to elimination of job discrimination. In 1971, for example, the U. S. Supreme Court ruled in Griggs vs. Duke Power Co. that arbitrary hiring standards that are not job-related are illegal. As a result of this decision and of amplification of the regulations relating to employment, personnel practices are now rigidly circumscribed.

An employer covered by the various laws must take steps to attract minorities when seeking to fill a position, and must conform to guidelines related to writing help-wanted ads. The Wage/Hour Division of the U. S. Department of Labor now provides a list of discriminatory terms that cannot be used in help-wanted ads. There are also specific restrictions about application blanks, interviews of potential job applicants, about questions potential employees can be asked, and even about personnel tests, all designed to prevent job discrimination.

Workmen's compensation laws

Every state now either has an elective or compulsory workmen's compensation law to provide benefits to employees injured or impaired on the job. Most of these laws, regardless of how they are structured, require employers to pay monetary benefits or reimburse medical and hospital expenses for any on-the-job injuries, occupational disease, or permanent, partial or total disability stemming from a job situation.

Occupational Safety and Health Act of 1970

This legislation imposes a duty upon each employer to provide a hazard-free working environment and though it probably would not affect the solo practitioner or small professional office, it could affect group practices. If so, the professional office must maintain records of occupational injuries and illnesses, provide annual summaries of occupational injuries and illnesses, keep workers informed of protections and obligations under the law, and so forth.

Other legislation, not recapped here, relates to workers' rights to organize and bargain collectively with employers and to provision of specified information about any pension programs or profit-sharing plans offered by their employer.

It's obvious the era of the consumer is here, and with it, a plethora of laws and regulations aimed at protecting the individual. There is also obvious overlap and conflict among federal, state and local laws so the whole area is fraught with confusion at present.

For the practitioner, such legislation related to employment and employment practices generally means more paperwork, more conformance, more care to avoid any actions that could smack of discrimination in the workplace. Though the physician dislikes the extra work entailed, he's probably largely in agreement with the legislative intent. Prudence requires the MD take these statutes seriously in years to come.

MSMS/A

Michigan's medical auxilians help consumers maintain good health

By Anita Yannitelli
Battle Creek

Community projects are among the most prominent of medical auxiliaries' activities. Members' enthusiasm and voluntarism extend from county to county across the state in many areas: family health, international health, AMA-ERF, legislation, membership, MDPAC, community health.

As we arrive at the midpoint of the year, outstanding health projects have been developing in immunization, geriatrics, scoliosis screening, GEMS (Good Emergency Mother Substitutes), and many others.

Alerted to assist the medical profession in controlling rising health costs, members utilize these projects to encourage consumers to learn healthful practices. The Washtenaw County Auxiliary have met with their county society to hear a panel discuss methods of cost-cutting in hospitals. Informed auxilians, knowledgeable about medical costs, can be effective representatives of the medical profession.

There is an emphasis among medical societies nationally to update immunizations of school-age children. Community Health committees in a large number of auxiliaries are working through county health departments as needed in the schools.

Scoliosis screening

In Genesee County, a full scale scoliosis screening project has been handled in 66 schools, screening 13,000 students. 200 medical auxilians were committed to the project. Mrs. Carroll LaVielle, president, stated, "This is a first for the schools on this large a scale."

Grand Traverse Tri-County Auxiliary participates in a similar screening program in the Traverse City Public Schools, according to Mrs. Kenneth Musson, president.

"Calhoun County Auxiliary is cooperating with the county health department's geriatrics screening clinic," said Mrs. Gregory Purchase, community health chairman. "The clinic is designed for all senior citizens over 60, to judge if they are getting adequate care, diet and medication and to determine if a need exists for a medical follow-up." Twenty auxilians are serving with the clinic as nurses taking histories and as escorts who direct patients to diagnostic stations.

GEMS program

Saginaw and Grand Traverse-Leelanau-Benzie Counties are active in the GEMS program. Essentially it's a babysitting class for boys and girls 12 years old or older, who are caring for babies and young children. The GEMS program is a national auxiliary project which follows a prescribed course of good babysitting skills taught by auxilians (or specialists they call in) concerning infant care, poison awareness and child development.

Cardio-pulmonary resusitation (CPR) courses for auxiliary members and spouses are gaining in impact in community and family health. The course gives the knowledge and skills necessary in an emergency. It requires two four-hour sessions for a certificate and courses are given by Red Cross, Michigan Heart Association and community colleges. Among counties deep in this project are Wayne, Calhoun and Saginaw. St. Clair County plans to offer a mini-course to members and Ingham County Auxiliary is making arrangements to offer the training.

Mrs. LaVielle

Mrs. Musson

Mrs. Purchase

These are only highlights of projects undertaken to promote the objectives of organized medicine. Many are launched at the request of county medical societies and all are initiated with approval of the medical society in each county. Some, such as legislative "Alerts," are carried out at the request of the AMA-Auxiliary upon approval of MSMS.

Too much to read?

"Physician, how are you doing keeping up with all the medical literature?"

If you are swamped — that's understandable.

Index Medicus is the "bible" of medical bibliography and lists all medical publications. That index has jumped from an average weight of four pounds during its first 60 years to the current weight of 66 pounds. And that is only a list of the publications, and contains no articles.

No wonder it's tough to keep up.

Mrs. Yannitelli is editor for the MSMS-A newsletter, "Auxilium."

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News

By Katie Brewbaker, MSMS staff

Robert R. Small, MD, is the coordinator of the new Community Emergency Service Advanced Emergency Medical System encompassing 10 communities in the Benton Harbor area. CES provides ambulance service manned by advanced emergency medical technicians licensed by the state to administer drugs under a physician's direction and perform more sophisticated services.

New director of medical education and chief executive officer of Saginaw Cooperative Hospitals is **Thomas J. Cinque, MD.** In addition, he will continue as assistant dean and professor of nephrology at the MSU College of Human Medicine.

Recipient of a cash award in a statewide technical writing contest sponsored by the Michigan Association for Medical Education is **Joseph Rich, MD,** resident at Pontiac's St. Joseph Mercy Hospital. Doctor Rich's paper was on cost containment in health care.

Arnold M. Weissler, MD, Birmingham, is new chairman of the Council of Clinical Cardiology of the American Heart Association. He was also elected to the AHA board of directors at its recent meeting in Dallas. Doctor Weissler is chief of medicine at Harper-Grace Hospitals and chairman of the department of internal medicine at the WSU School of Medicine.

Two new assistant deans in the U-M Medical School have been appointed. **Marie J. Paluszny, MD,** will serve as assistant dean for admissions and **Errol E. Erlandson, MD,** assistant dean for student affairs.

Alexander Blain, III, MD, who in 1974 was appointed by the mayor of Detroit to serve as a member of the five-man Detroit Zoological Park Commission, is new president of the commission for an indefinite period.

Hermann Pinkus, MD, professor emeritus of the WSU Department of Dermatology, is recipient of the Lila Gruber Cancer Memorial Research Award, granted by the American Academy of Dermatology at its recent meeting in San Francisco. The award is given in recognition of outstanding contributions in the field of cancer research.

The name of **Paul E. Ruble, MD,** will become a household word in Michigan soon. Doctor Ruble, of Grosse Point Park, will be imparting medical wisdom to readers of the *Detroit News* through his daily medical advice column. Doctor Ruble succeeds the late George G. Thosteson, MD, as author of this public service column.

Dolores Shelfoon, MD, practicing emergency physician in Bloomfield, Birmingham, and Pontiac, has been installed treasurer of the American Medical Women's Association.

William T. Unkefer, MD, Farmington, has been appointed by Governor Milliken to a 14-member task force charged with formulating policy toward legal and financial issues associated with the reduction of hospital bed capacity in Michigan.

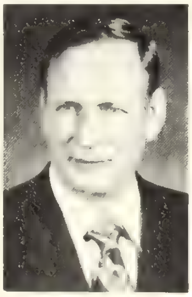
MSU's experimental program to encourage family practice research in Michigan has proven so successful it has become an annual program. The 2nd Annual Family Practice Research Day was recently held at MSU under the sponsorship of the MSU Department of Family Practice and the Michigan Academy of Family Physicians. More than 100 participants from 40 Michigan communities, plus Indiana, Ohio, and Canada, attended the conference. **Roy A. Gerard, MD,** chairman of the MSU Family Practice Department presented a plaque to **Jack M. Stack, MD,** Alma physician and a member of the MSU Board of Trustees, for the best paper by a practicing family physician on "Spontaneous Abortion and Grieving."

The citizens of Cheboygan expressed their thanks and appreciation to **Nicholas Lentini, MD,** by naming a day in his honor upon his retirement from practice. People crowded the Cheboygan Area High School at a special reception on Doctor Lentini Day to bide him and Mrs. Lentini farewell and wish them happiness as they left for their new retirement home in Florida.

A Michigan physician is one of five doctors appointed to handle the U.S. team next July in the Pan-American Games in Puerto Rico. **Roy Bergman, MD,** team physician for Escanaba area high schools, has been selected. Doctor Bergman has served as a member of the MSMS Planning Committee for the Sports Conference and as chairman of the Sports Planning Committee for the Upper Peninsula Sports Conference presented last fall in Marquette.

Many people express their appreciation and gratitude to physicians, nurses, and other paramedical personnel privately, but seldom are those who play a part in the lifesaving role publicly acknowledged for their service. This was not the case recently in Lansing. The parents of a young man critically injured in an automobile accident wrote a long letter to the editor of the *Lansing State Journal* expressing their deep appreciation to the physicians and auxiliary personnel for saving the life of their child.

Doctor Bergman



Doctor Ruble

Doctor Shelfoon

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When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Central Lake 49622

Korial J. Atty, MD (OBG)
20905 Greenfield
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Holland 49423

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Livonia 48150

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27552 Van Dyke
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Allen Park 48101

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Charlevoix 49720

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Detroit 48223

Disciplinary Actions, Michigan Board of Medicine

Meetings of October 5, 1978 and November 1, 1978

The following actions of the Michigan Board of Medicine are taken from official memoranda to MSMS and are not editorialized:

CARLTON F. BROWN, MD; SOUTHFIELD License suspended for one (1) year, permanent surrender of Controlled Substance Registration and Drug Enforcement Administration Registration.

DANIEL LEE FINK, MD; SOUTHFIELD Limited licensure issued and placed on probation. Applicant shall not apply for or obtain Controlled Substance Registration.

ROBERT S. NIXON, MD; BAY CITY Intent to deny application for restoration of Controlled Substance Registration.

EZRA S. SHAYA, MD; WARREN Place on a one (1) year probation, letter of reprimand to be issued.

PAUL LOUIS GRADOLPH, MD; FERNDALE Place on a one (1) year probation, letter of reprimand to be issued.

DEAN B. SMITH, MD; GRAND RAPIDS Issued a written reprimand. For a period of twelve (12) months, ability to prescribe or dispense Retaline and amphetamines restricted to his hospital practice.

Several Michigan physicians national specialty leaders

The recent Annual Report of the American Board of Medical Specialties lists the names of several Michigan physicians who provide leadership now to ABMS-recognized specialties.

The ABMS includes 20 primary boards and two adjunct boards, with five other national organizations as associate members.

Kenneth P. Mathews, MD, Ann Arbor, serves as secretary of the American Board of Allergy and Immunology, and also is a member of its board.

Norman D. Nigro, MD, Detroit, is secretary-treasurer of the American Board of Colon and Rectal Surgery. Board members are **James P. Muldoon, MD,** Grand Rapids, and Doctor Nigro.

Clarence S. Livingood, MD, Detroit, is the executive director of the American Board of Dermatology.

Walter P. Work, MD, Ann Arbor, serves as secretary-treasurer for the American Board of Otolaryngology, and is also a member of its board. **Frank N. Ritter, MD,** Ann Arbor, also serves on the board.

Trustee for the American Board of Pathology is **Murray R. Abell, MD,** Ann Arbor.

William C. Grabb, MD, Ann Arbor, is among the directors for the American Board of Plastic Surgery, Inc.

Duane L. Block, MD, Dearborn, is chairman as well as board member for the American Board of Preventive Medicine, Inc.

Serving as assistant secretary for the American Board of Radiology is **Kenneth L. Krabbenhoft, MD,** Detroit, who is also a board member.

Herbert Sloan, MD, Detroit, is secretary-treasurer and board member of the American Board of Thoracic Surgery, Inc.

Chairman-elect of the Association of American Medical Colleges is **John A. Gronvall, MD,** Ann Arbor.

WELCOME/*continued*

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Computerized heart cath unit at Ingham Medical

By Irma Kaufman
Lansing

An event of interest to the medical community occurred recently, when Ingham Medical Center, Lansing, installed a completely computerized cardiac catheterization unit, the first of its kind in the United States.

Ingham Medical has had a cardiac catheterization laboratory in its special studies department for several years, but growing utilization of the unit indicated that additional equipment was needed to handle increased demands. After evaluating the systems available, the Siemens unit was chosen, and installation was completed in May of 1978.

Information available immediately

The outstanding advantage of the new catheterization unit is that, because of the sophistication of the equipment, physicians receive accurate information immediately, instead of having to wait for results to be computed manually. An additional advantage to the physician is that the X-ray portion of the lab can obtain many anatomical views not available with the old unit.

According to Michael J. James, DO, cardiologist and medical director of the catheterization laboratory, about 100 procedures per month are performed, about half of which are heart catheterizations.

"By the time I have the patient stabilized and walking out of the lab, the computer report should be ready, and I just have to dictate the cineangiograms," he says. "With the new equipment, we can program anything we want into it."

The new unit is used primarily for cardiac catheterizations, while the older one is now used for other procedures, such as translumbar aortograms, carotid arteriograms, visceral angiography, cerebral arteriograms and pacemaker implants.

New lab's features

The new catheterization laboratory has biplane cineangiography capabilities, as well as the computerized physiologic data acquisition. The A-P plane is on a C-arm configuration, which can rotate about the patient. There is also a specialized table which is used to move the patient in conjunction with the C-arm to obtain specialized views of the cardiac circulation. To review biplane angiography, the unit is equipped with biplane video. This is particularly important with children for assuring quality angiograms.

The physiological monitor in conjunction with the PDP 11 computer has the ability to store hemodynamic data, which can be recalled at any time. Even the way in which wave forms were analyzed can be changed either during the procedure or after it.

How procedure works

To begin the procedure, the patient is given a local anesthetic. Then a catheter is inserted in a vein or artery and is manipulated into chambers of the heart or coronary arteries. Intracardiac pressure measurements are taken, and contrast agents may be injected to make blood vessels and the heart visible on X-rays and on a television screen. X-rays are taken at a speed of from 30 to 90 frames per second.

All of this is visible to the cardiologist and technologist on television monitors that display the fluoro and cine pictures. The procedure is also video taped for instant re-study. Physicians can replay the tape to insure that adequate information is obtained before ending the procedure, without having to wait for X-ray films to be processed. In the meantime, the computer is programmed to give instantaneous analyses of physiologic data required by the cardiologist, and by the surgeon if heart surgery is being considered.

The cardiac catheterization takes approximately one hour to complete. The patient feels only minimal discomfort. J. C. Kloepfer, MD, cardiologist, has been doing cardiac catheterizations at Ingham Medical since 1970. "The new equipment offers quite a contrast to what we had at the beginning," he says. "We used to use the fluoroscopic equipment in radiology until the special studies unit opened in 1972. Now, with the addition of this new unit, we can greatly increase the number of cases we do."

"Another important advantage," Doctor Kloepfer adds, "is that the efficiency of the new unit reduces exposure to radiation by roughly a factor of eight to the operator, and two to the patient."

LANSING STATE JOURNAL PHOTO BY DAVE WEBB

A view of the new cardiac catheterization laboratory through the windows of the control room.

Ms. Kaufman is public relations director, Ingham Medical Center.

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DUE TO RECENT retirement the position of medical director is open in Chase Center, a privately owned 233 bed extended care facility. Health care community is saturated with the philosophy of openness and cooperation. Logansport is a county seat town of 22,000 population in mid-north Indiana. Complete information will be forwarded upon request. Contact Rob James, Administrator, Chase Center, Logansport, IN 46947.

THREE YEAR APPROVED Psychiatric Residency Program now appointing for an immediate unexpected opening and for July, 1979. Small intensive psychiatric hospital, JCAH approved, affiliated with University of Iowa Medical College. Comprehensive program including two adult psychiatric units, adolescent unit, children's unit, alcohol and drug abuse unit, with innovative community liaison, and OPD. Eclectic approach. Situated in picturesque northeast Iowa near large cities with cultural advantages, but in rural setting. Ideal for family living. No financial sacrifice while learning. Top salary: first year $23,478, second year $24,648, third year $25,896; liberal fringe benefits; some housing available. Opportunity to join staff upon completion of training. All applicants must have completed one year in an American approved training program in internal medicine, family practice, or pediatrics or a flexible one year program, including four months in internal medicine. Write or call J. T. May, MD, Superintendent, or B. J. Dave, MD, Director of Education, Mental Health Institute, Independence, Iowa 50644.

POSITIONS AVAILABLE — With offices in Lansing, Oak Park and Traverse City, there are openings for physicians board certified or qualified as internists, family physicians or psychiatrists working with the Disability Determination Service under the Social Security Administration. Salary currently between forty-seven and fifty-eight thousand per year, plus 23% fringe benefits, including life, accident, long term disability, dental, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years service. Liability insurance not necessary. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7830. In Michigan, call toll free 1-800-292-2710.

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Positions wanted

FAMILY PRACTICE — Position desired by DO finishing one year internship in July 1979. Prefers western or northern Michigan. Contact: Lawrence Ulmer, DO, 735-1 Wellington Crescent, Mt. Clemens, MI 48043. 313/468-2318.

Miscellaneous

MICHIGAN PHYSICIANS MUTUAL Liability Company surplus certificate for sale. Basic value $1,000. Please call 1/616/343-5376 on Mon., Thurs., Fri., 9:30 a.m. to 4:30 p.m.

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COMPUTER FOR SALE — L-8500 series Burroughs Computer for sale. Has 20K of memory with capacity of an additional 28K. Storage is on memory-stripe ledger cards for readable backup of patient accounts. Programmed for 1-10 physicians. Medicaid, Medicare and Blue Shield Insurance forms completed at the time of posting. Contact Bruce Davenport, MD, 2424 Spring Arbor Road, Jackson, Michigan 49203. Phone 517/787-6960.

OFFICE SPACE FOR LEASE between 14 and 15 Mile Road on Utica Road, Fraser. Summer of 1979. Next to golf course, airport. Across from hockey, racquet ball and tennis complex. Near St. Joseph West and South Macomb hospitals. 313/772-5070, 313/286-5757.

WSU focusing on MDs' responsibility for dental caries

The Wayne State University School of Medicine has embarked upon a comprehensive national education program designed to draw attention to physician responsibility in dental caries prevention.

The objective of the School of Medicine's project will be to educate and motivate all physicians who care for children living in non-fluoridated water areas to prescribe fluoride supplements from infancy through the first 10 to 12 years of life.

The WSU philosophy is that the primary responsibility for prescribing fluoride rests with the physician because (1) all of the deciduous teeth and most of permanent teeth are calcified before most children see a dentist; (2) only 11 percent of children see a dentist by age five; (3) only one-third as many children from low-income families get dental care as those from high-income families; (4) research has shown the benefits of fluoride supplement are markedly diminished when not initiated until age four.

Directing the project is Frederick J. Margolis, MD, clinical professor of pediatrics at WSU School of Medicine. Doctor Margolis has been conducting independent long-term studies in an effort to determine the effect of fluoride on both deciduous and permanent teeth.

The project is funded by a grant from the W. K. Kellogg Foundation of Battle Creek to the WSU School of Medicine.

(Editor's note: A comprehensive report on the status of fluoridation and fluorides in public water supplies or communities served by public waters in each Michigan county has just been completed by, and is available from, the Michigan Department of Public Health Divisions of Dentistry and Water Supply.)

Deaths

Nicholas Delzingro, MD
Miami, Florida

Nicholas Delzingro, MD, 88, formerly of Genesee County, died Dec. 5. A general practitioner, Doctor Delzingro was a graduate of the Wayne State University School of Medicine. He was affiliated with Hurley, St. Joseph and McLaren General hospitals, Flint, and Goodrich Hospital, Goodrich.

Robert H. Durham, MD
Birmingham

Robert H. Durham, MD, Birmingham, died Dec. 20 at the age of 83. Doctor Durham had served as head of the general medicine division and as senior consultant in medicine at Henry Ford Hospital. A graduate of Johns Hopkins Medical School, Maryland, Doctor Durham was a specialist in internal medicine. He was a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians. He authored "Encyclopedia of Medical Syndromes."

Myron R. Stanton, MD
Detroit

Myron R. Stanton, MD, Detroit surgeon and psychiatrist, died Nov. 28 at the age of 68. Doctor Stanton graduated from Wayne State University School of Medicine and served as chief of surgery at the old Edith K. Thomas Hospital. He was also a member of the psychiatric staff at Wayne County General Hospital. During World War II, he served as an examining physician at the Armed Forces Induction Center. He was a member of the American Psychiatric Association and the Michigan Academy of Family Physicians.

Rex A. Wilcox, MD
Alma

Rex A. Wilcox, MD, 82, of Alma, died Oct. 23. Doctor Wilcox graduated from University of Michigan Medical School and was affiliated with Wilcox and Gratiot Community hospitals, Alma. He was a past president of the Gratiot County Medical Society, and was a member of the American Academy of General Practice.

Merle G. Wood, MD
Pentwater

Merle G. Wood, MD, Pentwater, died Oct. 1 at the age of 71. Doctor Wood graduated from the University of Michigan Medical School as a general practitioner. He was affiliated with Oceana Hospital, Hart. He was a past president and past secretary of the Oceana County Medical Society.

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f value in treatment of psychotic patients; should not be employed in f appropriate treatment. When using oral form adjunctively in convul- disorders, possibility of increase in frequency and/or severity of grand seizures may require increase in dosage of standard anticonvulsant cation; abrupt withdrawal in such cases may be associated with tem- y increase in frequency and/or severity of seizures.

TABLE: *To reduce the possibility of venous thrombosis, phlebitis, local ion, swelling, and, rarely, vascular impairment when used I.V.: inject y, taking at least one minute for each 5 mg (1 ml) given; do not use veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra- ial administration or extravasation. Do not mix or dilute Valium with solutions or drugs in syringe or infusion flask. If it is not feasible to nister Valium directly I.V., it may be injected slowly through the infusion g as close as possible to the vein insertion.*

inister with extreme care to elderly, very ill, those with limited pulmo- reserve because of possibility of apnea and/or cardiac arrest; con- tant use of barbiturates, alcohol or other CNS depressants increases ession with increased risk of apnea; have resuscitative facilities avail- When used with narcotic analgesic eliminate or reduce narcotic dos- at least 1/3, administer in small increments. Should not be administered tients in shock, coma, acute alcoholic intoxication with depression of signs.

precipitated tonic status epilepticus in patients treated for petit mal s or petit mal variant status.

drawal symptoms (similar to those with barbiturates, alcohol) have oc- ed following abrupt discontinuance (convulsions, tremor, abdominal/ cle cramps, vomiting, sweating). Keep addiction-prone individuals r careful surveillance because of predisposition to habituation/ endence. Not recommended for OB use.

acy/safety not established in neonates (age 30 days or less); pro- ed CNS depression observed. In children, give slowly (up to 0.25 g over 3 minutes) to avoid apnea or prolonged somnolence; can be ated after 15 to 30 minutes. If no relief after third administration, ropriate adjunctive therapy is recommended.

cautions: If combined with other psychotropics or anticonvulsants, fully consider individual pharmacologic effects—particularly with known pounds which may potentiate action of Valium (diazepam), *i.e.*, nothiazines, narcotics, barbiturates, MAO inhibitors and antidepres- ts. Protective measures indicated in highly anxious patients with ac- panying depression who may have suicidal tendencies. Observe usual cautions in impaired hepatic function; avoid accumulation in patients compromised kidney function. Limit oral dosage to smallest effective unt in elderly and debilitated to preclude ataxia or oversedation (ini- y 2 to 2½ mg once or twice daily, increasing gradually as needed or rated).

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance

INJECTABLE. Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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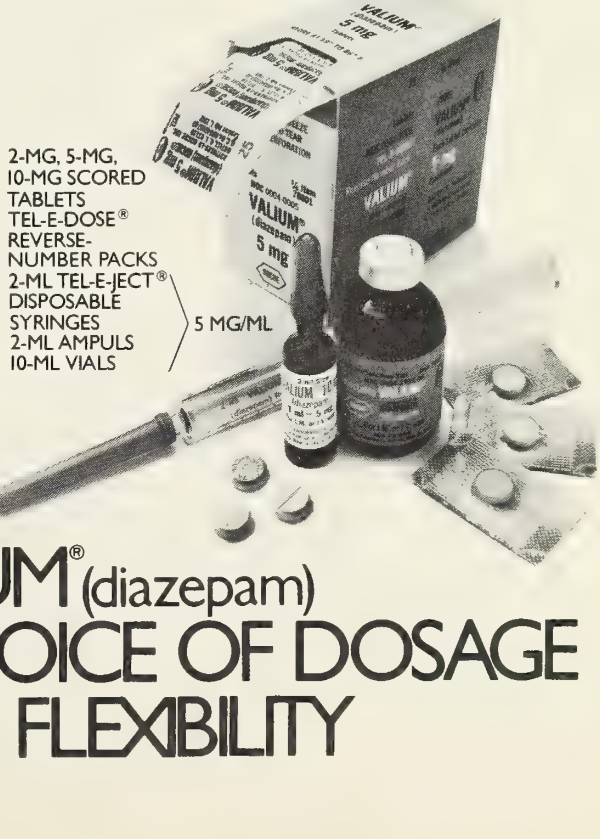

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LES

PRESIDENT LOUIS E. HEID-
, MD, is scheduled for a num-
r of appearances before
ty medical society meet-
g around the state during
coming weeks. His sched-
includes:

b 20--Kalamazoo Academy of
M dicine
r 13--Kent County Medical
S ciety
r 27--Huron County Medical
S ciety
l 21--Upper Peninsula
M dical Society

ddition, MSMS Council
rman Louis R. Zako, MD,
l meet April 10 with the
wa County Medical Society,
will attend the UPMS
ing.

* * *

E INJURIES, DIETS FOR ATH-
S AND PROPER CONDITIONING
l be among topics at the
M Conference on Medical
cts of Organized Athletics
ned April 12 at Towsley
er, University of Michigan
cal Center. The program
a registration form will
ar in the next issue of
gram. Please watch for

* * *

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it for the documentation
our CME activities.

BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine Medigram

VOL. 78, NO. 6 FEBRUARY 26, 1979

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Recent legislative developments involve Laetrile, anatomical gifts

A bill to "legalize" Laetrile in Michigan has been reported from the House Public Health Committee to the full House of Representatives, and action is expected soon. The bill would grant immunity from disciplinary action to physicians who prescribe Laetrile for cancer patients, and direct the Michigan Board of Pharmacy to establish standards for the manufacture of Laetrile in Michigan. Despite the unlikelihood of Laetrile being manufactured in Michigan under the statute, MSMS has opposed the bill on grounds it grants state recognition to the unproven substance.

The Public Health Committee shortly will take up HB 4002 to amend the Uniform Anatomical Gift Act. Under the proposal, a county medical examiner would be required to conduct a diligent search for the surviving next-of-kin, and lacking knowledge of an objection to the removal of eyes, the medical examiner would permit removal of eyes if such removal would not interfere with any subsequent investigation, autopsy, or post-mortem facial appearance. MSMS, while supporting the bill in order to make more corneas available to eyebanks, is also seeking legislation to make all usable body tissues available under the Anatomical Gift Act.

Michigan Supreme Court to hear MSMS amicus curiae brief

MSMS' amicus curiae brief in support of Sidney Freidman, MD, is one of several to be considered now that the Supreme Court has decided to hear Doctor Freidman's appeal. MSMS plans to file a brief on the merits of the Friedman countersuit of attorneys Peter Dozorc and Robert H. Golden. Both Doctor Freidman and the defendant attorneys appealed to the Supreme Court after the Michigan Appeals Court allowed only limited grounds for countersuit against the two attorneys. The Oakland County Circuit Court earlier had dismissed Doctor Friedman's case altogether.

CAPSULES/continued

FREDERICK F. VANDUYNE, MD, Flint, is chairman of the new MSMS task force to monitor HMO development in Michigan. The task force is being formed by The Council following the MSMS House of Delegates' call for study of the enrollment, subsidization and cost effectiveness of HMOs. The committee is to share its information with MSMS members.

* * *

C. J. TUPPER, MD, former scientific editor of *Michigan Medicine*, and former assistant dean of medicine at the U-M, will be installed March 12 as president of the California Medical Association. He is dean of the School of Medicine at the University of California at Davis.

* * *

IF YOU'D LIKE to take part in the MSMS volunteer legislative network, you may apply using the form printed in the Feb. 9 issue of *Medigram*. Interested physicians may serve as MSMS liaison with legislators in Lansing, and maintain close contact with legislators at home, through the network. The network was formerly the MSMS "Doctor of the Week" program.

Medical ethics requirements for Category I CME clarified

Category I "medical ethics" CME requirements for Michigan physicians, as mentioned in the new Publi Health Code, have been clarified somewhat by the Board of Medicine. Board executive Bert Brennan t the MSMS Committee on CME Accreditation Feb. 14 th discussion of ethics at almost any conference deal with patient management will meet the requirements To help MSMS members further study ethics, the MSM CME Programming Committee has appointed Andrew D. Hunt, MD, MSU medical humanities program head, to plan such courses for coming months. Doctor Hunt' efforts, and other MSMS ethics activities are spotlighted in the March issue of *Michigan Medicin* soon to be in the mail.

MSMS committee chairman visits Michigan congressmen

Richard J. McMurray, MD, Flint, chairman of the MS Committee on Federal Legislation, with MSMS staffe Bruce Ambrose, called on members of the Michigan C gressional delegation Feb. 13 in Washington, DC. W James Drake of the AMA Washington office, Doctor M Murray visited the offices of new US Senator Carl Levin, Congressmen David Stockman, Dale Kildee, Ro Carr, Carl Pursell and Robert Davis.

Doctor Malone re-elected MSMS Judicial Commission head

John M. Malone, MD, Farmington Hills, is beginning new term as chairman of the MSMS Judicial Commissi He was re-elected at the Commission's meeting Feb. Elected to serve as vice chairman is William C. Ba MD, Holland.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 78 No. 6, February 26, 1979

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Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine
Medigram

VOL. 78, NO. 7

MARCH 12, 1979

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CA SULES

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e dent. Other officers are
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t y, and W. E. Maldonado,
, ansing, treasurer. John
thony, formerly manager
e MSMS Department of
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n ce, has been appointed
n al manager of the corpora-
o Financial and estate
a ing, as well as practice
n gement consultations will
g soon. The PSG will be
a quartered in the new
o kwell Building addition to
M headquarters.

C PITAL BED REDUCTION for-
n as proposed by the State-
i e Health Coordinating
C ncil are explained on
a e 2 of this issue of
e igram. Don't miss this
ortant news.

I ISTER NOW for the 1979
S Conference on Medical
ects of Organized Athle-
s, planned April 12 in
Arbor. Program details
a registration form for
s major educational
nt for team physicians,
ches and trainers appear
page 3 of this issue.

Council orders membership poll on BCBSM contract

The MSMS Council plans to poll members of MSMS on a proposed agreement between Michigan physicians and Blue Cross/Blue Shield of Michigan. Plans to poll members were made at The Council's March 7 meeting. The proposed agreement, hammered out pursuant to House of Delegates action May 3, 1978, addresses four principles of BCBSM-physician relationships also voiced by the delegates. The advisory poll was ordered because The Council is recommending that the House of Delegates not adopt the document as currently presented. The Council feels, however, that it is necessary to poll the membership to lend further guidance to the House when it takes final action. The results of the poll will be communicated to the delegates before the House convenes May 4. Both Medigram and Michigan Medicine will publish an objective review of the proposed agreement, with two opposing commentaries, before the membership is asked to vote. In taking the action against adoption and to poll the membership, The Council also voted commendation to Donald K. Crandall, MD, chairman of the physician work group that worked out the pact with BCBSM, and to his committee colleagues, Frank Walker, MD, and John Bryan, MD. The draft agreement seeks to implement the four House of Delegates principles.

* * *

At its March 7 meeting, The Council also:

1) Capitalized the new MSMS-sponsored Physician Service Group, Inc., through the purchase of all 500 shares of common stock in PSG for the sum of $50,000. This makes MSMS the sole owner of the corporation, which was created to provide more and different services for MSMS members. Among the first services to be offered will be estate planning for members; other new and personal services are on the drawing board.

2) Voted outright opposition "with no quarter" on the proposed 91 percent occupancy rate per hospital under the state's hospital bed reduction plan. The Council termed the occupancy rate "too high and too rigid" to allow reasonable access to hospitals by patients. The proposed criteria and guidelines for hospital bed re-

(Continued)

MSMS members urged to contact legislators on effects of bed reduction guidelines below

The criteria and guidelines for the elimination of excess hospital beds in Michigan was approved by the Statewide Health Coordinating Council at its Feb. 8 meeting. The criteria and guidelines recently have been submitted to the legislative Joint Committee on Administrative Rules for final approval. Action by the committee must take place within 30 days or the criteria and guidelines are automatically considered approved.

The criteria and guidelines specify the formula listed below is to be used to determine the appropriate number of hospital beds. The most controversial elements of this formula are the target occupancy rates, particularly the 91 percent target for hospitals with more than 90 adult medical/surgical beds.

The concern has been expressed that due
fluctuations in admissions and the inclusion of special care units which must
operate at lower occupancy rates, a hosp
will be required to maintain an occupanc
rate of more than 100 percent on weekday
maintain a 91 percent occupancy rate ove
The result is a lower quality of health
due to over-crowded conditions and the i
ability to admit patients when necessary
MSMS and the Michigan Hospital Associati
thus oppose the proposed 91% occupancy r
for adult medical/surgical beds.

Physicians are urged to notify their leg
lators, particularly members of the admi
trative rules committee, of how the impl
mentation of these proposed occupancy ra
will affect patients. More information
appear in Michigan Medicine.

PROPOSED FORMULA
TO DETERMINE THE APPROPRIATE NUMBER OF HOSPITAL BEDS

$$\frac{{}^{1}\text{Projected Population}}{1{,}000} \times {}^{2}\text{Use Rate} \times \frac{1}{365} \times \frac{1}{{}^{3}\text{Target Occupancy Rate}}$$ ______ Adult & Pediatric Medical/Surgical Bed Need

+

^{4}OB Average Daily Census + ^{5}Z Factor ______ OB Bed Need

=

Hospital Bed Need for a Service Are

1. Projected population is the total population in the service area (including referrals from other areas) projected to 1984.

2. Use rate is calculated as the lesser of the historical use rate or 1,000 hospital day per 1,000 persons adjusted for age and rurality factors.

3. Target Occupancy rate =

Adult Medical/Surgical	Pediatric Medical/Surgical
66% for 1-15 bed hospitals	60% for 1-19 beds
67-73% for 16-25 bed hospitals	75% for 20 or more beds
74-84% for 26-50 bed hospitals	
85-89% for 51-75 bed hospitals	
90% for 76-89 bed hospitals	
91% for 90 bed hospitals or larger	

4. OB average daily census = number of births X $\frac{\text{*OB average length of stay}}{365}$

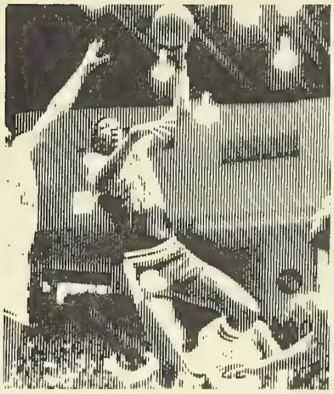
5. "Z" factor is a number derived from a standard distribution to assure that an OB bed will be available 98 percent of the time despite normal fluctuations in OB admissions.

(*OB average length of stay is traditionally set at 4.26 days for an uncomplicated delive

1979 Conference

Medical Aspects of Organized Athletics

Thursday, April 12, 1979
Towsley Center, University of Michigan Medical Center
Ann Arbor



Sponsored by: Michigan State Medical Society
Michigan Athletic Trainer's Society

The Michigan State Medical Society will grant 6 hours of Category I Continuing Medical Education Credit toward the state requirements. AAFP prescribed credits for family physicians also will be awarded.

8 a.m.	*Registration and Coffee*
9 a.m.	Welcome: Gerald A. O'Connor, MD, Chairman-Moderator, Department of Surgery, and team physician, University of Michigan Medical Center
9:05 a.m.	**"Hand Injuries in Sports"** Dean Louis, MD, Department of Surgery, University of Michigan Medical Center
9:20 a.m.	**"Diagnosis of the Acutely Injured Knee"** John A. Bergfeld, MD, Head, Section of Sports Medicine, Department of Orthopaedic Surgery, Cleveland Clinic Foundation, Team Physician, Cleveland Browns' Football Club.
9:40 a.m.	**"Current Concepts on Nutrition and the Athlete"** Robert White, CAT, Head Trainer, Wayne State University
10 a.m.	*Coffee Break*
10:15 a.m.	**"Physical Examination of the Knee, Video Tape Presentation"** Jack Hughston, MD, Clinical Professor, Section of Sports Medicine, Department of Orthopaedic Surgery, Tulane University
10:45 a.m.	**"Eye Injuries in Sports"** Gary Sandall, MD, Department of Ophthalmology, University of Michigan Medical Center
11 a.m.	**"Brachial Plexus Injuries"** John A. Bergfeld, MD
11:15 a.m.	Panel — John A. Bergfeld, MD, Dean Louis, MD, Gary Sandall, MD, and Robert White, CAT
12 noon	*Luncheon*
1 p.m.	**"Women's Athletics — Facts and Fancies"** Letha Hunter, MD, Department of Surgery, University of Michigan Medical Center
1:15 p.m.	**"Early Diagnosis and Treatment of Shoulder Injuries"** John A. Bergfeld, MD
1:35 p.m.	**"Rehabilitation of the Knee Joint After Injury — Closed Circuit TV presentation"** Kent Falb, CAT, RPT Lindsy McLean, CAT, RPT
2:05 p.m.	**"Sure You Can Play, But . . . (Preventive Sports Medicine)"** Douglas McKeag, MD, Department of Family Practice and Sports Medicine, Michigan State University
2:35 p.m.	**"Athletic Injuries — Potpourri"** Robert Anderson, MD, Director of Student Health Service, team physician, University of Michigan
3:05 p.m.	**"Taping Demonstration — Closed Circuit TV"** Robert White, CAT
3:35 p.m.	Panel — Robert Anderson, MD, John A. Bergfeld, MD, Kent Falb, CAT, Letha Hunter, MD, Lindsy McLean, CAT
4:15 p.m.	*Conference Ends*

REGISTRATION FORM

Please return to: MSMS Conference on Medical Aspects of Organized Athletics
PO Box 950, East Lansing, MI 48823 Phone: 517/337-1351

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City ____________________ **State** __________ **Zip** ________

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CAPSULES/continued

ROBERT E. RICE, MD, Greenville, has been re-elected chairman by the Michigan delegation to the AMA. Doctor Rice has served as chairman for three years. Elected vice chairman of the delegation is Richard C. McMurray, MD, Flint, while Robert D. Burton, MD, Grand Rapids, is new treasurer. The delegation now is laying plans for the AMA Annual Convention July 22-26 in Chicago.

* * *

MICHIGAN PHYSICIANS ARE ALERTED to a nationwide immunization campaign now underway, according to John L. Isbister, MD,, Michigan Disease Control Officer, Department of Public Health. "State and local school authorities and public health agencies are united in an effort to assure all school children are immunized," says Doctor Isbister. "This is particularly important in Michigan where, in the last two years, we have virtually led the nation in numbers of reported measles and rubella cases." Michigan physicians may be contacted by parents for information.

Council/continued

duction now lie before the Legislative Rules Committee, which must either accept or reject them within 30 days.

3) Referred to the MSMS Division on Government Relations the recommendations of a task force on public health services. Called for under the new Public Health Code, the public health service recommendatio would include, in addition to traditional health department services, some primary care services. The recommendations go to the Department of Public Healt for implementation.

State postpones Medicaid demands; offers MDs voluntary cost option

Active MSMS members now are receiving letters from t governor and legislative leaders, and also from MSMS Medicaid Liaison Committee Chairman David Siegel, MD Lansing, urging voluntary cooperation to help reduce Medicaid costs. The governor's/legislative leaders' letter promises to postpone mandatory Medicaid cost containment measures proposed by the Michigan Depart ment of Social Services if physicians will voluntari cooperate to reduce unnecessary costs. Doctor Siege sees the governor's and legislative leaders' offer a "a golden opportunity to demonstrate our ability to meet the challenge."

The MDSS by March 15 would have required physicians fill out a prior authorization request form, documen reasons for admission, then wait for MDSS approval. The MDSS also proposed postponement of increases for 20 percent of physicians' reimbursement screens. Th MDSS is calling a meeting March 14 of Medicaid providers and practitioners to discuss alternatives to the original proposals.

Emphasizes Doctor Siegel, "If we assess our daily decisions on choice of treatment, I am confident...we can reduce (medicaid costs)."

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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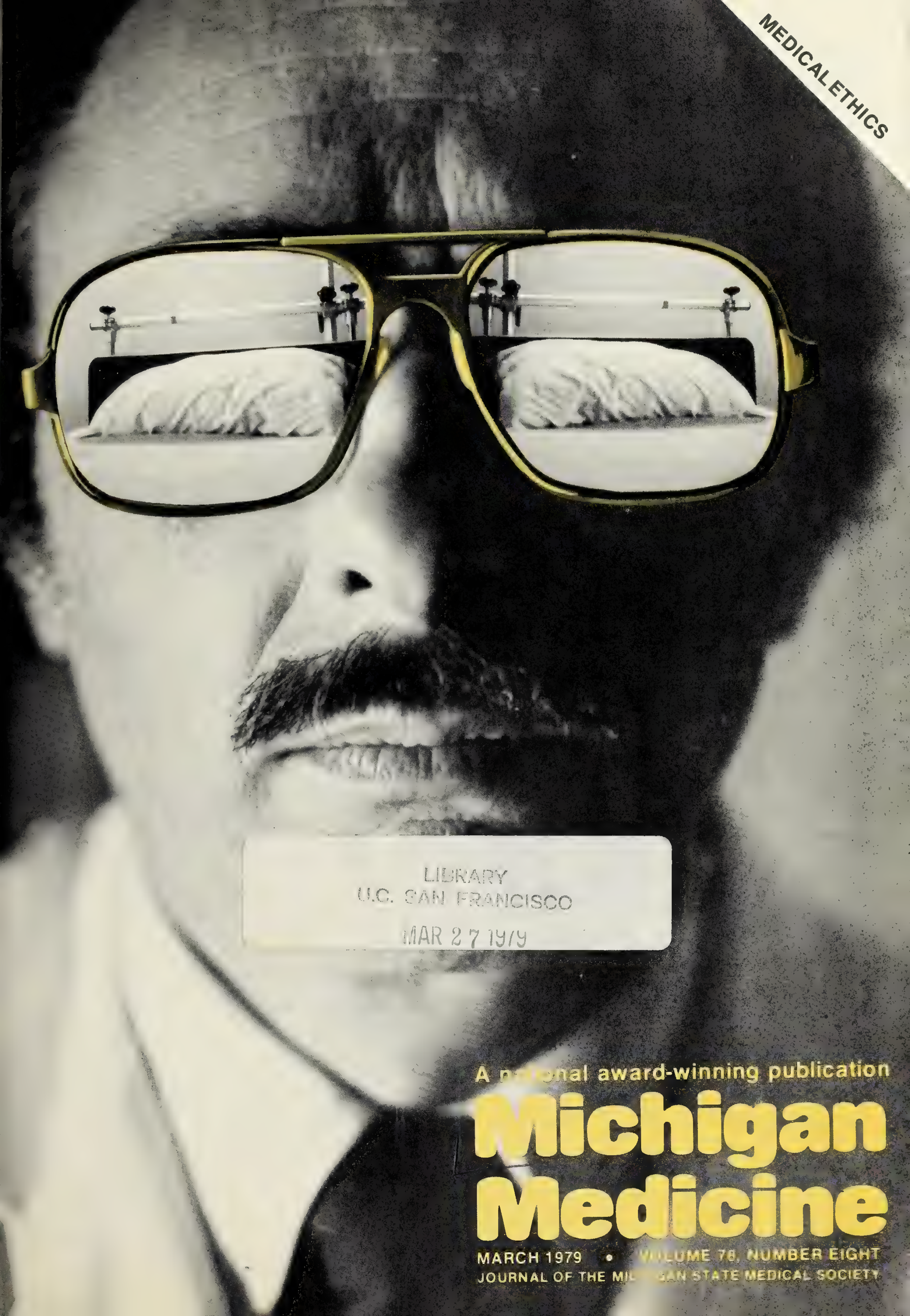

MEDICAL ETHICS

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MARCH 1979 • VOLUME 78, NUMBER EIGHT
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March 1979

Michigan Medicine

Contents

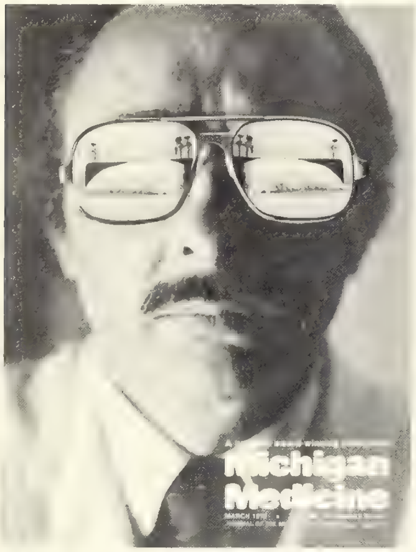

PHOTO BY MERT SCHOLTEN

Solving ethical questions of medical practice is the subject of this month's special section beginning on page 111. Readers may study several typical ethical dilemmas, then read further for the proposed solutions of four experts.

Special Section

111 **MSMS actively seeks to aid Michigan physicians with medical ethical problems; New CME requirements call for courses in medical ethics; proposed problems test readers' skills at handling ethics problems;** Maryanne Butt; Andrew D. Hunt, MD; Martin Benjamin, PhD; Arthur Kohrman, MD, and Bruce L. Miller

Features

117 **How MSMS members benefit**
118 **1979 MSMS sports medicine conference coming April 12**
120 **Report on activities since the 1978 MSMS House of Delegates**
129 **Legislative profile: Rep. Joyce Symon;** Willah Weddon
130 **Pontiac honors Doctor Furlong;** C. R. Shelton
134 **Two Michigan physicians and their unusual adventures;** D. Bonta Hiscoe, MD, and Robert D. Burton, MD
144 **How Muskegon County attracted 28 new physicians in two years;** Robert C. Packer, MD
161 **Wayne County Medical Society president and past president offer views;** C. Jackson France, MD, and Carl A. Gagliardi; MD
162 **MSMS photo contest underway**

Departments

121 **MSMS Q/A**
122 **Committees**
124 **Views;** Robert S. Holm, MD; Joseph R. Oldford, MD, and Stuart L. Cohn, MD
132 **News**
139 **Category I courses**
141 **Ad index**
152 **Welcome**
154 **MSMS/A**
156 **Meetings**
164 **Deaths**
167 **Classified ads**
168 **President's page**

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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MSMS works to help members in variety of medical ethics situations

By Maryanne Butt
***Special to* Michigan Medicine**

The Michigan State Medical Society is taking the first steps toward a new understanding of "medical ethics" and what they mean to its member physicians in today's current practice setting.

New CME rules and regulations which were drafted by the Michigan Board of Medicine and took effect Nov. 3, 1978, require Category I credits in "medical ethics with accredited sponsorship." The new rules, however, do not specify how many credits in medical ethics will be required.

According to Bert Brennan, executive director of the Board of Medicine, the new requirement "has not been solidified to the extent there are any guidelines at this point." The board is planning to wait until the audits of physicians' Category I credits take place at renewal time, to study what physicians throughout the state have done regarding courses in ethics. Mr. Brennan says it will determine at that point the specifics of the new rule.

MSMS ethics courses

The MSMS CME Programming Committee is in the process of forming a task force on medical ethics courses to help determine these specifics. Andrew D. Hunt, MD, of Michigan State University, has been named chairman.

According to Doctor Hunt, who is coordinator of MSU's Medical Humanities Program, there is a lack of clarity among physicians on what the Board of Medicine means by the term "medical ethics."

He says most physicians educated in traditional medical schools have thought of "medical ethics" as those patterns of behavior defined in the AMA Principles of Medical Ethics.* He says it must be made clear to physicians that, with today's advanced medical technology, "medical ethics" encompass much more than the "etiquette" described in the Principles of Medical Ethics. "Medical ethics are the application of ethical logic to value issues in medical practice. They are value issues for which science cannot provide an answer."

MSU's Medical Humanities Program has recently submitted a proposal for a three-hour course in medical ethics to be presented at the MSMS Annual Scientific Meeting in November, according to Doctor Hunt.

Abuse task force

Another step MSMS has taken toward a new understanding of medical ethics is the recent formation by the MSMS Council of a task force to investigate alternative solutions to alleged abuse and over-utilization in the medical field. MSMS feels the task force is necessary to protect the public and itself, according to Richard Rapport, MD, of Flint, the Council's representative on the task force.

Concerns of this new task force include ways to deal with alleged laboratory and X-ray excesses, especially in office settings; labeling of laboratory tests to maximize fees; over-utilization of hemodialysis; psychiatric clinics billing for services of social workers and psychologists; purchased sick leaves; improperly performed abortions; prescriptions for street drugs; the sale of pharmaceuticals by physicians for profit; overcharges to patients by BCBSM participating members, and the use of "unproven gadgets" in office settings.

The task force will propose alternative solutions to the MSMS Countil.

MSMS Judicial Commission

Since the 1960s, the MSMS Judicial Commission has been responsible for dealing with specific ethical questions for member physicians. It governs all matters pertaining to ethics, grievances, mediation, professional conduct, and discipline binding on the Society and each of its component medical societies. Its chairman is John M. Malone, MD.

According to Chapter 11, Section 8, of the MSMS Constitution and Bylaws, the Judicial Commission has the authority, in matters of ethics, mediation, grievance, discipline, and professional conduct of members, to: make binding interpretations of the Constitution and Bylaws; make ethical interpretations and decisions in accordance with the standards of the AMA; have sole appellate powers at the state level for members of component county societies; entertain and exercise original jurisdiction when requested do so by any component county society or by any member in good standing of the society; make and promulgate rules and regulations pertaining to ethics, grievances, mediation, professional conduct and discipline of members; appoint committees and adopt rules, regulations and procedures as are deemed desirable in carrying out the functions and purposes of the Commission.

In this special section, *Michigan Medicine* presents three simulated medical cases involving ethical dilemmas. The reader is invited to answer questions and prepare responses to the ethical problems before turning the page to study proposed solutions.

The cases and solutions are prepared by Andrew D. Hunt, MD, and his staff at Michigan State University, who have presented medical ethics courses for Lansing-area physicians for several years.

The cases and proposed solutions are typical of those which will be prepared for future Category I MSMS courses on medical ethics.

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*The AMA has appointed an ad hoc committee to review a new draft of the Principles of Medical Ethics. The final draft will be presented to the AMA House of Delegates at its annual meeting in July.

Medical ethics situation A

Case 1

A mother brings her 4-year-old daughter to the family physician with a complaint of irritability and runny nose of two days' duration. The physician diagnoses a viral cold, based on history and physical exam. The mother is urging him to "give her something to make her feel better," and the physician assumes that she will not be responsive to advice to give the girl fluids and bed rest only, so he gives the child an injection of penicillin. The mother leaves feeling satisfied with the physician's treatment.

Case 2

The patient is a 54-year-old white female, a widow, who has been complaining of chronic low back pain for two years. Two surgeries for ruptured disc have been unsuccessful in relief of symptoms. X-ray and physical exam findings are inconclusive for organic disease of the musculo-skeletal system.

The surgeon who has been following this patient holds an interview with her in which he explains in some detail that he is going to try a new, potent medicine which he is sure will provide dramatic relief of her pain. He then gives her some sugar pills. On this regimen the patient reports a significant relief of her pain problem. The surgeon then concludes that he has proven that the patient's symptoms are "all in her head," and he calls for a psychiatric consultation.

1. **In which of these two cases has a placebo been used?**
2. **In each case, was the physician's behavior ethically appropriate? Was it in keeping with the "scientific" practice of medicine?**
3. **In Case 2, ought the surgeon to charge the patient for the course of drug therapy given?**

Please turn to page 113 for proposed solutions.

Medical ethics situation B

For several months this 52-year-old woman and her family had been involved in a generalized denial of the implications of her diagnosis of advanced colon cancer. They also denied their denial — while stating when asked that they understood the illness and its serious nature, the content of their actual conversations and behavior indicated continued hope for full recovery and a long life span. Delayed healing from the initial surgery prevented institution of chemotherapy or radiotherapy; the physicians had grown quite pessimistic about the woman's chances for living more than a few months. She required a great deal of care on the surgical floor because of multiple complications of her disease and of the surgery.

In the sixth month of her hospitalization, the patient began rather rapidly to develop lethargy and lowered consciousness; dehydration and electrolyte imbalance were suspected as possible causes. The physicians felt this was an excellent opportunity for a relatively rapid and painless end for the woman's physical and emotional suffering. If they corrected this problem she could live another year or two, conceivably, with little chance of being free of pain. The physicians also noted that if she lived she would continue to require a good deal of medical attention, further contributing to the drain of scarce medical resources. While the family was clearly in favor of maximal attempt to correct the present problem, the physicians attributed this attitude to their psychological denial with their unrealistic assessment of the actual consequences.

1. **Should the physicians act to correct the fluid-electrolyte problem at this time?**
2. **Is it proper for the physicians to consider the problem of scarce medical resources in making this sort of decision? If the physicians do not concern themselves with the problem, who should? If the physicians do concern themselves with it, how are potential conflicts with the best interests of the individual patient to be resolved?**

Please turn to page 114 for proposed solutions.

Solution 1 to situation A

Case 1

A patient's trust in the honesty and integrity of the medical profession is one of the practitioner's most valuable resources. Thus any time a physician tells a "white lie," its overall presumed benefits must be carefully weighed against its ethical, therapeutic, and economic costs. In the cases before us I believe that the physicians, though aiming to do the right thing, have seriously overlooked or underestimated some of the significant costs of their decisions.

In Case 1 the benefits of the injection of an active placebo are presumably the mother's satisfaction and the greater likelihood that she will be more responsive to the physician's sound advice about fluids and bedrest. The costs are: (1) the risk of a severe reaction to the antibiotics and possibly contributing to the girl's developing a resistance to it; (2) the compromised autonomy and personhood of any subject of deception; (3) unnecessary expenses; and (4) given a better educated public and increased coverage in newspapers of medical matters, the likelihood of the mother's eventually becoming aware of the physician's deception. This last is especially important inasmuch as the resulting mistrust will seriously threaten both the entire institution of medicine and the health of future patients.

Therefore, these high costs plus the availability of patient education as a satisfactory alternative lead me to conclude that the "treatment" cannot be justified.

And to the economic objection that the time it would take the physician to educate the patient would cost more than the injection, I have two responses: (1) even if this were so, the noneconomic costs listed above still outweigh the benefits; and (2) over the years this sort of patient education will more than pay for itself in economic terms.

Case 2

The surgeon in Case 2 believes that his use of an inert placebo has been justified by its usefulness in making a preliminary diagnosis of a frustrating medical complaint.

The costs of this procedure, however, also outweigh its benefits. Among the costs are: (1) the possibility the search for organic disease has been abandoned prematurely; (2) the compromised autonomy and personhood of the patient (her consent to the treatment could hardly have been informed); and (3) the very strong possibility that the psychiatric consultation will reveal the surgeon's deception and hence contribute to mistrust of medicine, which will then lead to diminished health.

If the suspicion that the patient's symptoms were psychosomatic was sufficient to justify administering a placebo, why was it not also sufficient to directly justify the psychiatric consultation?

Finally, it is important to distinguish the placebo *effect* from the administration of placebos. The former is a way of characterizing healing which is attributable to the doctor-patient interaction, though not to any specific medication. The *placebo effect* adds greatly to a physician's effectiveness and requires no deception. It would be a tragic irony, then, if an indiscriminate reliance on placebos, which do require deception, would in the long run severely impair the capacity of physicians to take therapeutic advantage of the placebo *effect*.

— **MB**

Solution 2 to situation A

Case 1

The physician's action in giving the penicillin injection, knowing that the child had a "viral cold" can be analyzed from the bases of two styles of medical practice; namely the paternalistic style in which the physician makes all decisions for a conforming patient, and one which acknowledges the validity of informed consent.

1. *From the paternalistic position*, the scientifically trained physician has presumably identified the child's condition as a common cold, for which an antibacterial substance such as penicillin would have no therapeutic effect. His own judgment then, surely was to withhold an antibiotic. He must also have been aware of the possibility of inducing penicillin allergy or the appearance of penicillin-resistant organisms should secondary infection occur. In his own mind, then, the injection was clearly not in the best interest of the patient, and his action was unethical.

2. *From the position of practice according to the doctrine of informed consent*. The injection was given without explanation to the child's mother, who presumably is under the impression that penicillin is useful in the treatment of the common cold. Assuming the mother to have been fundamentally interested in her child's welfare, it is logical to assume a rational response by her to a statement of the physician's reasons for not giving penicillin. His "assumption that she will not be responsive to advice" is an inadequate reason for not giving such advice. Again, from the perspective of the doctrine of informed consent, his action does not seem to be an ethical one.

Case 2

Here, a placebo has clearly been given, in contrast to Case 1, where there was no explanation given to the patient.

The literature is filled with arguments pro and con the use of placebos. Deception is a necessary correlate to placebo giving. I take the position that such deception is never justified even though immediately beneficial effects accrue to the patient. Ultimately lack of trust is likely to develop not only between the affected patient and the placebo-prescribing physician but also between her and the profession at large.

In this case, it seems probable that the diagnosis of neurosis could have been achieved by appropriate interviewing sessions, which would have led to a far better response to the ultimate psychotherapy than that emanating from a referral based upon deception, which fact would have had to be explained to her by the psychiatrist.

In my opinion, then, the physician here was not only not ethical, but was not practicing good scientific medicine.

— **ADH**

Solution 1 to situation B

At first inspection, this case would seem to describe a situation in which "letting-to-die" is seen as ethically and morally acceptable as opposed to "helping-to-die," and that the patient's natural course and physiological deterioration provided a convenient opportunity.

However, missing completely from the discussion is any indication of the patient's wishes; one must assume from this brief case presentation that prior to the acute deterioration the patient was conscious and able to participate in discussions about her own care. If, in fact, her "lethargy and lowered consciousness" are related to electrolyte imbalance and dehydration, it seems likely that with minimal additional effort and using very standard techniques for an already hospitalized patient these could be corrected; it would be my inclination to do so. Then the physician, the family and the patient could together discuss future management and ascertain that the family's wishes were, in fact, those of the patient herself. It might then be appropriate to enter into a discussion in which all the parties participate (but with the patient's wishes paramount) to decide which measures will be taken to further prolong life.

Physicians are making decisions concerning the allocation of scarce medical resources all the time; a decision to maintain a terminally or seriously ill individual alive at great expense inevitably means that those resources are not available for others. In the absence of a moral and ethical system which encourages discussion of deliberate priority-setting, these are often set by default; that is, by the absence of discussion or confrontation. Yet the history of Western medicine with its imperatives for doing all that is feasible for the individual patient places the physician on the horns of an exceptionally difficult dilemma.

At the present time in our society we do have the opportunity, (and, I believe, the obligation) to involve patients wherever possible in decisions concerning the measures to be used in prolongation of life. However we have not yet developed systems which will allow us to make priorities as to which of a set of potentially eligible patients is to receive the limited resources available.

Physicians do, however, make these decisions frequently, if passively, and discussions of this sort should reveal to us the necessity of vigorous involvement of the physician community in the setting of priorities for distribution of resources through the various regulatory and advisory bodies which in recent years are beginning to attempt to grapple with this problem. —**AK**

Solution 2 to situation B

The relationship of patient and physician is one of personal care, characterized by the physician's obligation to benefit the health of the patient and the patient's right to receive beneficial care.

Though neither party may understand or describe the relationship in terms of rights and obligations, they manifest them by their mutual expectations; each party acknowledges that his conduct causes expectations in the other and that these expectations are justified. To meet these expectations is fidelity, to disappoint them is faithlessness.

Fidelity requires that judgments about the care of the patient will not be based on factors bearing no relationship to what will benefit the patient. To employ a treatment which is not thought to be most beneficial for the patient in order to gain experience in its use or to gain knowledge of its side effects is an obvious example of lack of fidelity to the patient.

For the physician in the instant case to limit treatment of the patient because of a concern for the efficient allocation of scarce medical resources is a similar violation of fidelity, for the choice of care is based not on what will benefit *this* patient, but on the remote and abstract notion of efficient employment of resources. This should not be confused with physician determinations of how to allocate his or her resources in the face of competing needs of patients. Nor does the restriction on considering the efficient allocation of medical resources imply that a patient may not take into consideration the cost of the medical care.

But how does a physician respond to the related problems of spiraling costs of health care and its efficient allocation? These are problems of policy at the national, state and hospital level. Granted, they have not been solved, and no solutions are looming on the horizon. But this does not grant a physician the authority to address the problems through a failure of fidelity to patients.

The first question in the instant case, should the physician act to correct the fluid-electrolyte problem, should be answered by the patient, if possible, and if not, by the patient's family. — **BLM**

Solutions to Situations A and B on this and the preceding page were prepared by the following:

Solution 1 to situation A: Martin Benjamin, PhD, associate professor of philosophy; assistant coordinator, Medical Humanities Program, MSU College of Human Medicine.

Solution 2 to situation A: Andrew D. Hunt, MD, professor of human development, coordinator of Medical Humanities Program.

Solution 1 to situation B: Arthur Kohrman, MD, professor of human development, and associate dean for educational programs, MSU College of Human Medicine.

Solution 2 to situation B: Bruce L. Miller, associate professor of philosophy, Medical Humanities Program.

Study of medical ethics most helpful in scientific age

Doctor Hunt

By Andrew D. Hunt, MD
East Lansing

The style of medical practice in the United States was affirmed by the AMA Code of Ethics in 1849, elaborating the fundamental importance and characteristics of the doctor-patient relationship. To the physician was assigned the responsibility for decision-making in the interest of the patient. Physicians had to make such decisions and to care for their patients humanely and according to the highest standards. Patients, according to the code, had to comply with physicians' decisions. Such compliance was a necessary condition for a continued and successful relationship.

It would appear the American public of that time, homogeneous and small by comparison with today, accepted and trusted physician dominance in medical decision-making and care.

Rapid progress in medical science and dissatisfaction with the many proprietary medical schools were among the forces leading to the Flexner Report in 1910. As a result, most medical schools not based in universities were closed and the scientific basis for modern medical education and practice was firmly established.

The "basic sciences," then, rather than the nature of the helping process between physician and patient, became the fundamental basis of medicine. The values by which medical student performance is judged became oriented around knowledge of the scientific facts relevant to a patient's condition rather than understanding of and sympathy toward the sick person's needs and welfare. The acquisition of information about a patient became a value and end in itself, sometimes without reference to coincident discomfort or cost.

In deference to our early tradition, however, the "art" of medicine, though poorly defined, is generally stated to coexist with science. Science, nonetheless, predominates, with "art" getting scant attention in medical education, text books, or journals. Science, publicly published and objectively presented, is of great interest to the public, which has become extensively informed, legally aware, and increasingly insistent upon sharing decisions in matters pertaining to its health, including personal medical care. The very nature of scientific medicine, then, seems to preclude a return to a style of practice in which physicians' decisions alone are the determinants of medical care.

Studying ethics helps

What can study and understanding of medical ethics do to help? In general, ethics studies deal with the "art" of medicine, or the process of relating medical science to human needs, and concern themselves with values. The behavioral and social sciences help by providing relevant data on attitudes and ideas, behavioral patterns of various groups and cultures, and skills needed for effective interpersonal interaction.

Medical ethics, through application of rigorous rules of logic based on relevant moral and ethical theory, seek to ascertain what ought to be done in given situations. Once the right things to do have been determined, the way has been prepared for humane, patient-oriented application of scientifically formulated medical care.

In everyday relationships of physicians to a scientifically and legally aware public, consideration of ethical process and principles can help with such issues as informed consent, use of placebos, truth-telling, and the use of one's patients in randomized clinical trials.

A second area of usefulness is in those complex situations which the scientific method is incapable of resolving. Classic examples are the problems generated by our technology's capacity to maintain life irrespective of the patient's or family's desires.

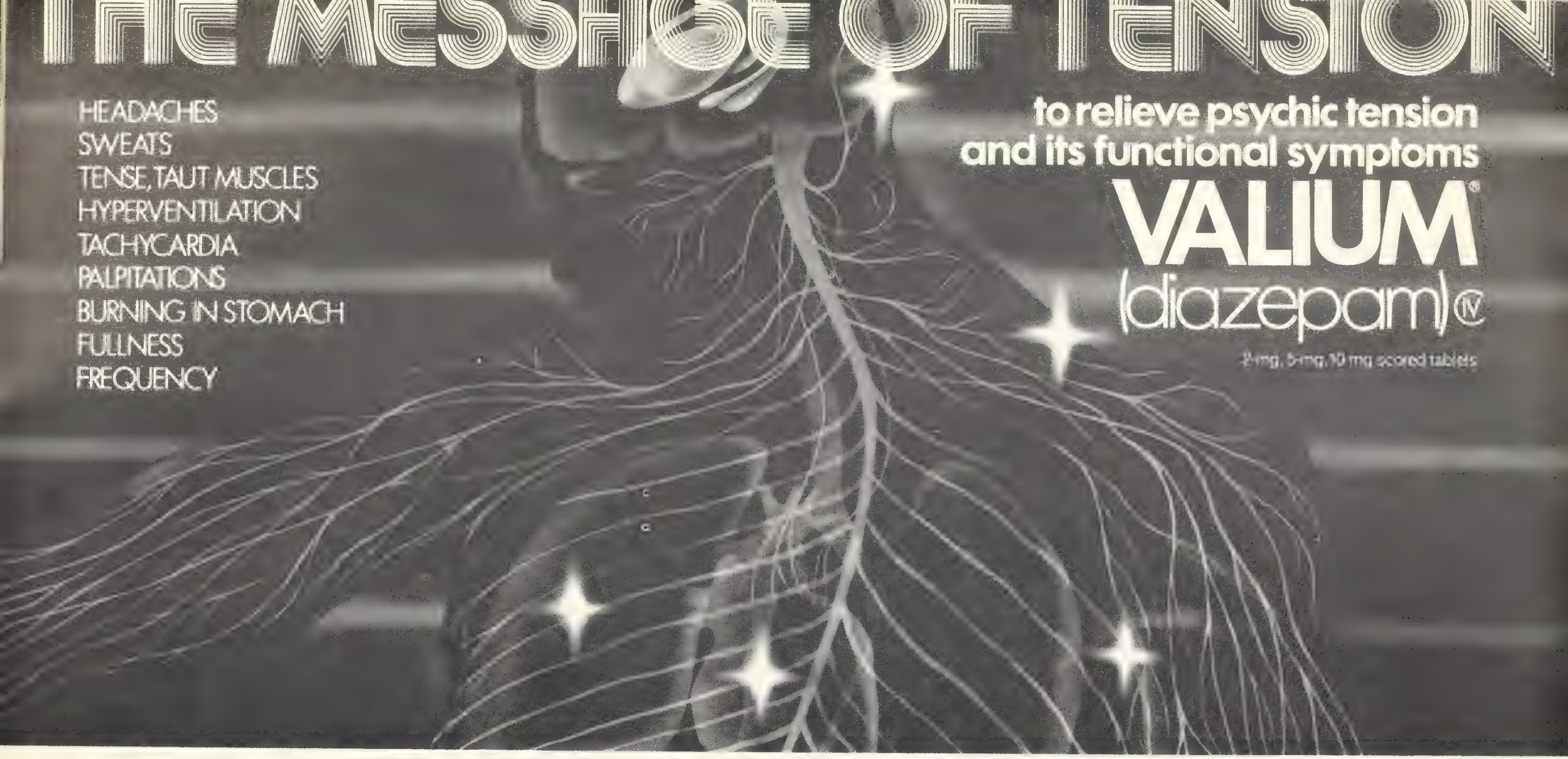
Finally, there are public policy issues impacting upon us as a group, such as allocation of scarce resources, health insurance, hospital regulations concerning abortion, and research on human subjects.

Local experience background

We have had several years' experience in the Lansing hospitals with ethics conferences approved for Category I continuing medical education credit. A case is presented in such a conference, and discussed by a panel usually consisting of a staff physician, a philosopher specializing in medical ethics, and a lawyer, theologian, or other related health professional. Comment from the floor and freely expressed difference of opinion are encouraged. Logical argument and defense of one's position are stressed. Sometimes, agreement is reached on a solution and plan of action; other times, the essential ambiguity of a situation is reinforced, and the validity of multiple options becomes apparent. Participants learn through involvement, and have access to pertinent reading materials.

In summary, at a time in which the very succsss of scientific medicine seems paradoxically to be in part responsible for difficulties not only for ourselves in the pursuit of our professional goals, but also between us and an ever more complex and more fully-informed public, medical ethics can be a very helpful discipline. Its specific inclusion as an approved topic for CME credit in Michigan is highly appropriate and forward-looking.

Doctor Hunt is coordinator, Medical Humanities Program, and professor of human development, Michigan State University.



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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating) Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy

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Here's how you benefit as a member of MSMS

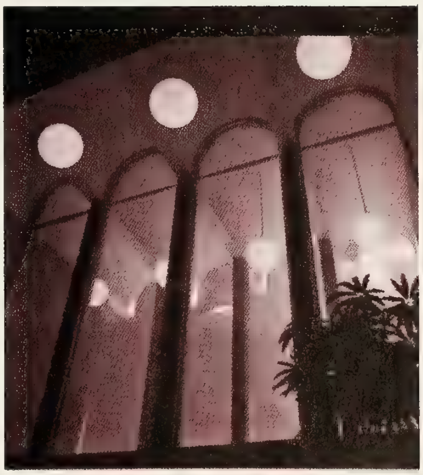
When Michigan physicians join MSMS, they benefit from a wide range of member services which can be classified as direct and indirect aids.

The MSMS Member Benefit Task Force recently compiled the following list of services for its own review.

MSMS members are urged to read and save this list for help in recruiting non-member physicians to join the state society. It's truly an impressive list.

Direct member benefits

- Publication each month of *Michigan Medicine*.
- Publication twice each month of the *Medigram* newsletter.
- Sponsorship each fall of the MSMS Annual Scientific meeting.
- Sponsorship each spring of the Michigan Conference on Maternal and Perinatal Health.
- Sponsorship each spring of the Annual Conference on Medical Aspects of Organized Athletics.
- Presentation each month of the live "Housecall" phone-the-doctor panel program over Channel 56 in Detroit.
- Support of the AMA-ERF appeals to raise funds to facilitate loans to medical students and provide unallocated funds for all medical schools.
- Periodic reports on Legislation to all members.
- Staff and assure physicians representation in Capitol Building.
- Provide staff support to MDs on HSAs, SHCC, and other government bodies.
- Maintain library of legislative bills available to members.
- Receive, research and respond to individual physician queries re: CME problems, Medicaid problems, Planning problems, etc.
- Arrange upon request meetings between legislators and physicians, or other government personnel and MDs.
- Conduct workshops, seminars and other meetings on public issues as indicated.
- Travel programs.
- Directory of members.
- County officer newsletter.
- Statistical information on membership.
- Insurance programs including Life, Health, Special Accident, Disability, Medical Assistant, Professional Liability, and Professional overhead expense.
- Auto Leasing program.
- Practice Management Seminars.
- Fee Surveys.
- Third Party Payor advice.
- Malpractice claims analysis.
- Financial planning advice.
- Michigan Doctors Study Club — Study/Ski Seminars.



Indirect member benefits

- "Lobby" physician viewpoints in Capitol building.
- Monitor State Health Coordinating Council and espouse physician views.
- Monitor appropriate governmental agency meetings and espouse physician viewpoints.
- Review and comment on all legislation.
- Maintain active liaison with Governor's office.
- Serve as juncture between Michigan doctors and AMA Washington office.
- Review and comment on rules and regulations as they are promulgated; inform members when they are effective.
- Monitor HMO and IPA developments.
- Provide liaison with the 10 PSROs.
- Accredit health care delivery systems in Michigan jails for the AMA program.
- Coordinate physician input in BC/BSM benefits for major motor groups.
- Coordinate physician placement for National Health Service Corps program.
- Develop practical guides for physician initiation in controlling medical care costs.
- Assist CME Programming Committee in developing courses on medical care costs.
- Provide liaison with BC/BSM regarding new health care programs.
- Provide liaison with MSMS legal counsel regarding BC/BSM litigation.
- Staff House of Delegates.
- Work with three medical schools to support common concerns.
- Cooperate with state departments of public health and mental health.
- Provide CME accreditation of hospitals and specialty societies.
- Provide health cost analysis.
- Facilitate arbitration.
- Carry out third party negotiations.
- Invest society equities.
- Provide administrative work for specialty societies and health related organizations.

Annual sports medicine conference planned for April 12 at Towsley Center

Conditioning, early diagnosis, treatment and rehabilitation of athletic injuries will form the nucleus of sessions to be offered at the 13th Annual Conference on Medical Aspects of Organized Athletics April 12, at the University of Michigan's Towsley Center in Ann Arbor.

Team physicians, coaches, and trainers are invited to this annual event which will be held this year in conjunction with the Michigan Athletic Trainers Society meeting.

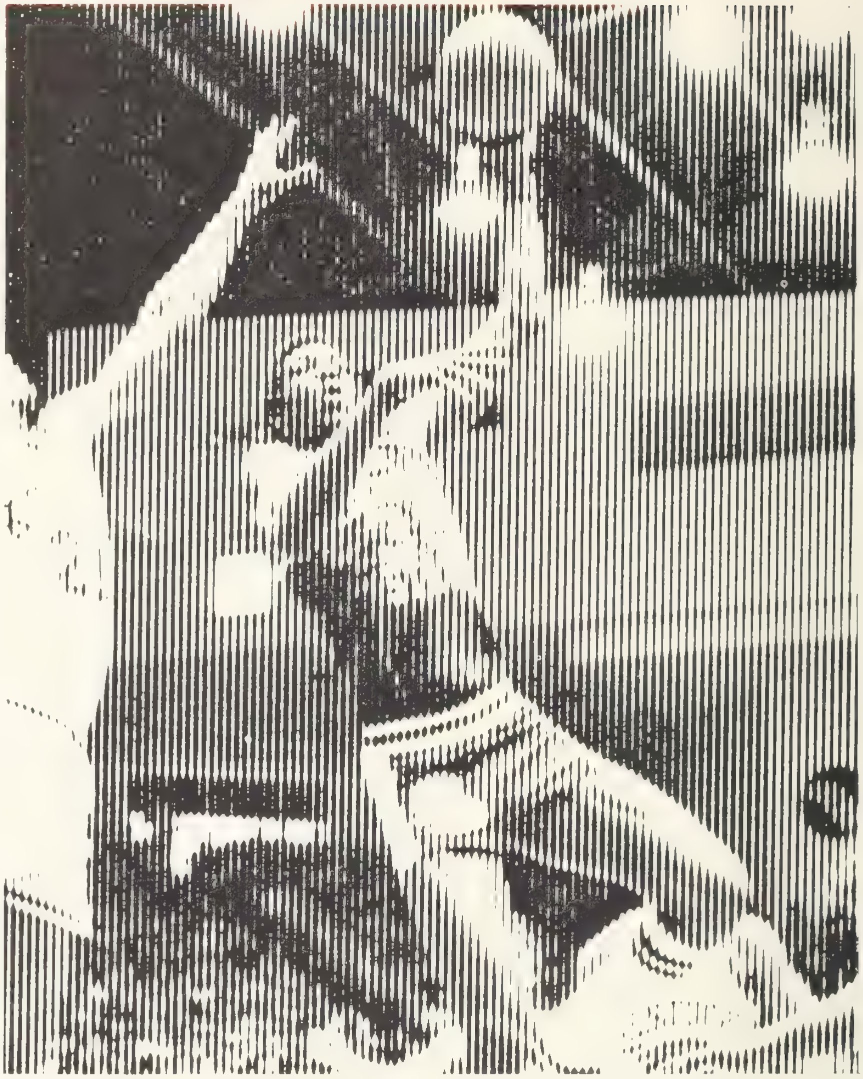
The day-long session will carry Category I CME credit. Conference chairman Gerald O'Connor, MD, Ann Arbor, says he hopes to see presentations on shoulder injuries, runners' injuries, athletics and nutrition, injuries to women athletes and knee injuries.

Doctor O'Connor has been in contact with key medical authorities on sports injuries and will recommend them to the committee as speakers.

"We're completing a program which should be of interest and value to sports-minded physicians and will also appeal to coaches, trainers and anyone else with a concern for athletes and their injuries," says O'Connor.

MSMS already has received preliminary inquiries about the program in early January. The 1978 Conference proved so successful that a last-minute move to a theatre was necessary to accommodate the overflow registration of more than 300.

Physicians interested in attending may obtain registration forms and a complete program from MSMS. Please call or write Mert Scholten, MSMS headquarters, who is staff coordinator for this year.



Clinics building opening

The Health Care Institute is to open this month for patient care in the new WSU University Clinics Building. The opening will occur "hopefully by March 1," Martin Barr, acting vice president for health affairs, says.

All outpatients will be transferred from hospitals in the medical center to HCI by the end of June.

Plans are also being made for three different events to mark the HCI opening.

According to Barr, a ceremony will be held when patients are first accepted for care and later a formal joint dedication will be held with the new Detroit General Hospital as soon as DGH is completed next June or July. The third event, an international symposium on primary care, will be sponsored by the University and HCI "in early fall, possibly October," Barr said.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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MSMS delegates' directives in 1978 result in variety of actions

Since the 1978 MSMS House of Delegates, MSMS leaders and staff have worked diligently to carry out the actions called for by the delegates who met at the Hyatt Regency Dearborn.

Here is a list of some of the activities which have resulted from the 1978 resolutions:

Medical record confidentiality

Resolution 2 directed that the problem of the medical record and its confidentiality be dealt with appropriately by a Council Committee.

Three things have occurred in this regard: (1) The Attorney General has ruled that patients should have access to their own records upon request; (2) A series of legislation has been introduced in Michigan to assure confidentiality of medical records held by third party payors. Although this legislation did not pass in 1978, similar bills should be anticipated in 1979; and (3) The Council Chairman has directed a sub-committee of The Council to address this issue.

Opposition to certificate of need

Resolution 4 directed MSMS to strongly resist certificate of need legislation at all levels.

Both MSMS and the AMA have been resisting certificate of need for private physicians' offices at state and federal levels. The line in Michigan was drawn by PHSRP, regarding CON for outpatient radiology and pathology but not for primary patient care offices. The matter will rise in the federal Congress as planning legislation is introduced in 1979 and MSMS will provide support to AMA opposition.

HMOs

Resolution 8 requested The Council to recognize concerns re HMOs as a high priority activity. The Council has appointed the Committee to Monitor Health Maintenance Organizations. The Committee will share its findings with the membership through *Michigan Medicine* and send its annual report to members of the 1979 House of Delegates.

FMG education, licensure

Resolution 25 directed MSMS to seek amendments to the Health Professions Assistance Act, to abolish the Visa Qualifying Exam and support graduate programs that accept qualified candidates regardless of race, creed, color or national origin.

The objectives of this Resolution are established AMA and MSMS policy and an amendment to the Health Professions Assistance Act will be introduced in 1979 to effect this policy.

Hospital arbitration programs

Resolution 27 directed The Council to develop with Michigan hospitals adequate arbitration programs for hospital personnel.

The MSMS and Michigan Hospital Association staffs have discussed the possibility of developing a program to further educate the hospital personnel and the public on the use of arbitration as a method of resolving professional liability claims. The re-writing of the arbitration booklet has been recommended to the staff of the Insurance Bureau. The Arthur Young and Company was retained by the Insurance Bureau to assess the effects of arbitration and they advised the Bureau to conduct an informational campaign on the arbitration process. Thus, the MSMS and the MHA will support the Bureau's effort.

New AMA member dues

Resolution 46, urging MSMS to work through its delegates to the AMA to change AMA policy to allow reduced dues for new AMA members, was referred to the AMA Board of Trustees. The board is conducting in-depth studies of its dues program in anticipation of schedule changes.

Future health care systems

As instructed by Resolution 53, MSMS has initiated a Physician/HSA Support Center with objectives cited in the resolution. The support center is staffed and operational on a two-year demonstration basis.

Media/press relations

Resolution 60 encourages county societies to establish media/press relations committees, and directs MSMS to consider the feasibility of conducting a special workshop to train members of component committees.

The Committee on Public Service appointed a task force to consider this Resolution. The task force recommended a workshop on press relations for MSMS components and for the specialty societies. The Committee on Public Service concurred, and a workshop is being scheduled for early 1979.

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

MSMS Q/A

FOR: W. E. Maldonado, MD, Chairman
MSMS Committee on State Legislation and Regulations

Doctor Maldonado

"Can a team physician (under contract with a school) come under the Good Samaritan Act for treating someone at a ball game? Can the physician come under the terms of the act if he is treating a player from his team? How about a player for another team?"

The Good Samaritan Act applies to a physician or registered nurse who in good faith renders emergency care at the scene of an emergency, where a physician-patient relationship did not exist prior to the advent of such emergency, and exempts the physician from civil damages liability as a result of acts or omissions by the physician, except in cases of gross negligence or wilful and wanton misconduct. The physician treating a student from the school he has contracted his services to probably would not fall under these circumstances, as a physician-patient relationship would already have existed. A physician treating a spectator or student from another team probably would fall under the Good Samaritan Act, as such a relationship would not have existed prior to the treatment.

FOR: Roy J. Gerard, MD, Chairman
MSU Department of Family Medicine

Doctor Gerard

"I recently received a one-page survey from the Michigan Statewide Health Manpower Survey Office in East Lansing. The last section of the survey used terminology I was unfamiliar with. Can you please explain what the term "Post Graduate I, II, and III" means?

The term "Post Graduate" is fairly new in usage. It replaces the old use of "Interns and Residents." For example:

Post Graduate I = Flexible internship, or year I of the residency
Post Graduate II = Residency Training Programs
III = Residency Training Programs
IV = Residency Training Programs

The above terminology should not be confused with Life-Long Continuing Medical Education classifications.

FOR: Emanuel M. Steindler, Director
AMA Department of Mental Health

"An MD in our community has a drinking problem. Can you tell me what assistance the AMA may give us to deal with this situation?"

The AMA has encouraged state and county medical societies to organize programs to help physicians who have problems with alcohol or other drugs, and who are in other ways physically or psychiatrically ill. Several county societies in Michigan are active in this regard, and the Michigan State Medical Society provides coordination and overall publicity for these programs. Mert Scholten is the MSMS staff person to contact for further information.

The planning committee for the 1979 MSMS Annual Scientific Meeting Nov. 13-15 is arranging more hands-on participation for physicians.

1979 MSMS Scientific Meeting will see many innovations

By Katie Brewbaker, MSMS staff

New ideas and innovative programming techniques are the hallmark for this fall's MSMS Annual Scientific Meeting.

The advisory task force for the 1979 MSMS Annual Scientific Meeting already has begun its work for the Nov. 13-14-15 session at the Hyatt Regency Dearborn.

Whenever applicable, course directors are being urged to approach their presentations from a multi-age perspective. Several courses are planned to have a specific "from alpha to omega" theme.

To make each program a maximum learning experience, emphasis will be given to the use of small, informal group sessions whenever possible. More "hands-on" and "wet clinic" type presentations will be held. Case studies will be used to embellish presentations. In some instances patients may be brought into the meeting, and more interplay between the speakers and the audience will be encouraged by expanding discussion periods.

The Task Force wants the 1979 Annual Scientific Meeting to continue being a unique, complete continuing medical education opportunity for physicians, in keeping with the precedent set by the dynamic Robert F. Wilson, MD, who served as the chairman of the ASM program committee during the past three years.

1979 program chairman is Samuel M. McMahon, MD, Lansing, who is associate professor of medicine at Michigan State University and director of medical education at Ingham Medical Center.

The specialty organizations and medical schools have been contacted, urging them to continue their active roles. Information is coming in daily regarding the programs they are planning and suggestions for speakers.

In addition, the task force is reviewing the topics recommended by the doctors who attended last year's meeting.

Some of the subjects being explored are: anti-arrhythmics, beta-blockers, bronchodilators, vasodilators, congestive heart failure, antibiotic therapy, cutaneous manifestations of systemic diseases, acute and chronic diabetes mellitus, athletic injuries, drug dependence, alcoholism in the medical profession, sexual problems, plus many others.

The members of Doctor McMahon's Advisory Task Force are Edward Cotton, MD, Marcellus; Frank Cox, Jr., MD, Detroit; Thomas F. Downham, II, MD, Taylor; Kenneth Krabbenhoft, MD, Detroit; David R. Rovner, MD, East Lansing; James C. Stanley, MD, Ann Arbor; and Joan C. Styker, MD, Detroit.

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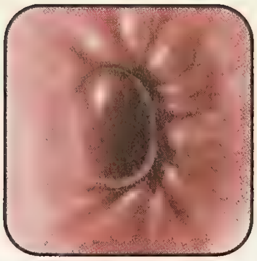
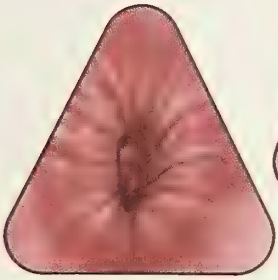


External hemorrhoids



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Good telephone technique aids in pediatric emergencies

Doctor Holm

Articles on this page and on page 125 are a continuation of dialogue started in the February issue of *Michigan Medicine,* when management of emergencies was featured.

By Robert S. Holm, MD
Grand Rapids

In pediatrics the initial contact with medical care is usually by telephone. The call is initiated most often by a parent. But few parents are medically sophisticated enough to volunteer all pertinent positives and negatives in the history which allow an easy decision. The doctor or nurse answering the call must be able to ask the questions to clarify what action (if any) needs to be taken.

This article focuses on those questions that can help sort the emergency from the routine calls in some common pediatric problems. The problems discussed here are croup, diarrhea, meningitis and abdominal pain. The article assumes that the caller has taken a basic history and now needs some special clues about the possible urgency of the situation, and that he uses *non technical* English to ask the questions.

Croup

Parents are naturally frightened when a child wakes in the night with respiratory distress. The doctor must be able to distinguish ordinary croup from severe croup and from acute epiglottitus.

Epiglottitus symptoms generally come on less suddenly and are more severe. The children are not able to swallow and are drooling. High fever is usually present. Epiglottitus is a major pediatric emergency, and if fever, drooling and more gradual onset are described, get the patient to the hospital *now*.

When these symptoms are not present, the following program will treat most croups satisfactorily, and identify those who need hospital care. Initially, give a dose of an antihistamine-containing cough syrup and start up the vaporizer in the bedroom. Take the child to the bathroom, close the door, turn on all the hot water faucets (but not the fan) and let the room fill with steam while holding and calming the child.

When the child is breathing well, put him/her back to bed with the vaporizer running. If he/she does not settle down by the time the hot water runs out, wrap him/her in a blanket and take him/her outdoors. When hot steam does not calm the crouper down, the cold night air usually will. If croup continues after 20-30 minutes outdoors, head to the hospital.

Diarrhea

Physicians who care for children regularly get frightening histories of children with gastroenteritis, and then see the child who is in no trouble. Parents often seem to exaggerate the number and size of the stools (and the extent of associated vomiting, when present), probably because of the unpleasant messes they are cleaning up.

Since dehydration is the worry, questions should focus on those symptoms. The dehydrated child will show progressive lethargy, eyes that appear to be sinking back into the head and are without tears, a tongue that appears shrunken in a dry, sticky mouth, and in the male, wrinkling and shrinking of the glans penis.

If the child is playful, alert and comfortable (though messy), an emergency does not exist. One word of caution — if the parent seems intoxicated, mentally dull and confused, and unable to give answers that seem meaningful, check the child.

Meningitis

Meningitis is one of the few febrile illnesses in children that cannot safely wait a few hours to be seen.

Children's doctors often see meningitis with few symptoms ("Boy, am I glad I did *that* tap!") and others with dramatic meningismus who do not have meningitis. The careful doctor will look closely for symptoms that suggest meningitis and do the spinal tap whenever he/she thinks *maybe* it should be done.

Telephone symptoms that suggest meningitis are progressive lethargy, especially in a child who lies very still and cries when moved, and unwillingness to look down. Most children resist and complain when someone forces their neck to flex, so it is better to have the parent sit the child up and jingle keys by the abdomen and see if the head will flex without fuss. If the child is alert, up and around, and willing to look down, meningitis is extremely unlikely.

Belly ache

Belly ache is one of the big headaches in child care. The vast majority are cramping, characterized by pain-free intervals and usually with vomiting and diarrhea. Appendicitis and other serious belly aches produce constant pain as a rule. Having the patient jump up and down can help localize a pain in the appendix area. The presence of increasing toxicity symptoms — lethargy, high fever, and abdominal distention all suggest an emergency.

Summary

Good telephone technique can help the physician distinguish the routine from the emergency, and some hints are presented here about some common pediatric problems.

Doctor Holm is chairman of the Michigan Chapter, American Academy of Pediatrics.

Improving urologic emergency care depends on better MD education

Doctor Oldford

By Joseph R. Oldford, MD
Detroit

A genitourinary emergency exists when a patient presents with a clinical situation which is either life-threatening, impairing the function of a genitourinary organ, causing intractable pain, or producing a septic situation. The event which may lead to this clinical situation might be either trauma or obstruction of a genitourinary organ.

The patient who presents with hematuria, oliguria or anuria, pain, mass or sepsis may truly be an emergency and should be dealt with as such.

Treatment initially should be directed towards control of hemorrhage, pain and sepsis, preservation of the function of the genitourinary organ involved and an immediate attempt to diagnose the exact problem that exists with the aid of clinical examination, urinalysis, excretory urography, retrograde urethrography where applicable, cystoscopy and retrograde pyelography where applicable, and angiography where applicable.

The patient who presents with a renal injury requires blood replacement where a shock situation presents and then immediate diagnosis by means of excretory urography. If this fails to diagnose the situation, immediate renal angiography may be needed. Where avulsion of renal vein or renal artery is apparent, emergent surgical intervention is life-saving. Where intrarenal or extrarenal hemorrhage or urinary extravasation occurs without the blood loss being more rapid than blood replacement and no expanding mass or sepsis intervening, most patients can be treated conservatively with bedrest and close observation unless one of the aforementioned conditions ensues.

Handling internal injuries

Ureteral injuries whether due to trauma or iatrogenic causes may go unrecognized for a period of time until the urinary extravasation produces a large urinoma. But when they are recognized, treatment should be directed towards reestablishing the continuity of the ureter.

Urinary bladder injuries require immediate diagnosis by means of retrograde cystography and this will indicate whether an intraperitoneal or extraperitoneal rupture of the urinary bladder exists with extravasation of the contrast material in the respective area. Treatment of both the intraperitoneal and extraperitoneal ruptures of the urinary bladder should be directed towards immediate drainage of the ruptured bladder with surgical drainage of the perivesical spaces to prevent abscess formation.

Urethral injuries: In patients who undergo severe trauma to the pelvis and lower abdomen in which possible transection of the membranous urethra is suspected, a retrograde urethrogram performed immediately will document the diagnosis. It is generally believed that early surgical management consisting of suprapubic cystostomy with evacuation and drainage of the perivesical space is the treatment of choice. At a later time, once healing of the fractures and resolution of the hematoma has resulted, then a secondary repair of the ruptured urethra can be conducted on an elective basis.

Priapism is a genitourinary emergency in view of the fact that delay in treatment of this condition will result in a permanent loss of function of this genitourinary organ, namely, impotence. Immediate effort should be made to diagnose the cause for the condition. Where it fails to respond to conservative means such as spinal anesthesia or treatment of other initiating causes, immediate shunting by either open surgical procedures or needle procedures should be performed as soon as possible to salvage the organ.

Torsion of the testicle is another genitourinary emergency which has to be treated within a four-hour period of time in order to prevent loss of function of the involved testicle. Where a high index of clinical suspicion exists, surgical exploration is mandatory immediately. Where a torsion is found and corrected, surgical fixation of the contralateral testicle should also be performed in an effort to prevent torsion at a later time in the contralateral testis.

Evaluating emergency care

In the field of urology, most emergencies are handled well once they reach the major emergency rooms of the hospitals within our state. The only problem is deciding which patient should be sent to the emergency room for proper care and here is where the inadequacy really exists: namely, misdiagnosing torsion of the testis as epididymo-orchitis, and by the delay in treatment losing the function of the testis. There also is the failure to recommend hospitalization for the patient who presents with non-visualization of one kidney on excretory urography. As a result the function of one kidney may be lost due to delay in immediate diagnostic studies. In my opinion, this is the area where handling of emergencies in urology could be improved by alerting physicians as to the nature of the genitourinary emergencies and impressing upon them the time involved with salvaging genitourinary organs.

Doctor Oldford is president, Michigan Branch of the American Urological Association; chief of urology, Harper-Grace Hospitals, Detroit, and clinical assistant professor, College of Medicine, Wayne State University.

HSAs are arenas of conflict; physicians are essential to success

Doctor Cohn

By Stuart L. Cohn, MD
Alpena

What is the provider's role in a Health Systems Agency (HSA)?

HEW decides for HSAs just who are providers, and physicians are among them. Providers must be on HSA boards because they deliver the services HSAs talk about, and providers are involved with what is happening now and what will happen in the future.

Positively, providers on HSA boards:

1) Have expertise about health care delivery;

2) Have special points of view;

3) Are able to implement decisions in their framework;

4) Are aware of the present state of the art in their own disciplines, and

5) Represent powerful groups that can make or break an HSA decision.

The negatives are:

1) They have their own self-interests;

2) They often have conflicting viewpoints;

3) They are more aware of illness than health;

4) They can scuttle decisions they believe to be not possible, applicable, or desirable.

It is difficult to separate our training and experiences as physicians to become conscientious HSA members — to go from interest in individual patients to becoming responsible for the health and illness needs of a community.

My personal view is that I represent people who may become patients; in the milieu of HSA I must represent them all fairly; yet our discipline has trained us to represent each one as an individual.

This dichotomy is the heart of some of our fears. If HSAs fail in solving this potentially devastating dichotomy, in my opinion, they will have failed. Local providers are essential to the ultimate success of the health systems plan as it unfolds. Providers make the system go.

Other peoples' perspectives

HSAs must be concerned not only with providers' viewpoints; providers need information and education from consumers. Physicians frequently talk too much to each other; they must get out and be concerned with what is going on in the world, must learn other peoples' perspectives, must not isolate themselves within their own disciplines.

HSAs are arenas of conflict, with providers, consumers and government officials as contenders. Conflicting ideas, feelings, experiences and knowledge are the context of HSAs' decision-making processes.

An HSA will make decisions based on the expertise of providers, consumers and government officials. Solutions should be based on reasonable data and debate; we hope a decision will be reached with which everyone can live. The professions which make up the provider constituency cannot, and should not, make those decisions alone. Historically, health care was a great privilege. More recently it has been considered a right for all citizens of the United States; now it is rapidly becoming an obligation for everyone and the next step may be that we are coerced to live in a healthy fashion.

HSAs and agony

These are societal problems, and HSAs are a segment of society which must make some decisions on the distribution of health care and the dollars to pay for it. In implementation, some individuals will suffer, and we, as physicians, will be responsible for those persons.

We are making that dilemma the HSAs' dilemma. Providers will not take the responsibility for that type of decision alone. The HSA also must go through the agony of knowing that a therapeutic modality, a diagnostic test, some needed service may not be available to a specific individual. That is a harsh reality for HSA.

Providers are on the HSA boards to give them information and insight and to assist and join with them in making decisions. Those decisions should not be cast in concrete; they can be changed.

If society is willing to spend more, we might do more. With fewer dollars, we must do less, but must constantly try to improve what we are doing so the ultimate goal of healthy individuals in a healthy society, a society that tries to stay healthy and prevent disease, can offer good quality health services fairly and universally, as well as democratically. This should be our goal. We cannot, and should not, cheat eventual death; we must be concerned about the quality of an individual's life.

The dialogue is beginning, and will continue. HSAs are not an end; they are only the start. They may not be the ultimate problem-solvers, but we have some very good guidelines. They are, stated simply: ethics, morality, and democracy.

With these as our guidelines — and they are not issued from Washington — we can begin to achieve some of the agreed-upon goals.

Doctor Cohn is a family physician and president-elect of the Northern Michigan HSA. He also is on the boards of his area PSRO and of Blue Cross/Blue Shield of Michigan.

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Rep. Joyce Symons hard worker as chairman of health subcommittee

The following article is the ninth in a series. The articles, written especially for Michigan Medicine *by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.*

By Willah Weddon
Special to Michigan Medicine

State Rep. Joyce Symon's most recent action in the health field was the introduction of the bill establishing a legal definition of death, which is now incorporated in the revised public health code. This legal definition was vital to physicians in their efforts to contain the cost of professional liability insurance.

The tiny, red-haired legislator's prime interest has been in health since she was first elected from Allen Park, 14 years ago. Appointed to the mental health committee during her first term in office, vice-chairman her second and chairman her third, she held the office for six years. In this capacity she was responsible for revising the state's mental health code.

Dialysis diabetes bills

In 1967, Mrs. Symons introduced legislation to assist people needing treatment on kidney dialysis machines. She held the entire house in session until 11 o'clock one long night until members included her amendment which set aside $300,000 for this purpose. Michigan became one of the leaders in this field and it has been a continuing program ever since. Typically, she battles each year for appropriations.

While serving on the Public Health Committee, Mrs. Symons authored the legislation providing funds for diabetes research on an annual basis. "If a bill is a good one, it is worth working for," she contends and is known for nudging senatorial committees if they do not take action on bills she's ushered through the house.

Currently serving on the House Appropriations Committee, (the first woman ever appointed to the powerful 18) Mrs. Symons is chairman of the public health sub-committee.

Reservations on new code

Always concerned about keeping taxes low, she has reservations about the recently revised public health code.

"The cost may be more than the public anticipated," she cautioned. "Especially with the tax reform situation, I'm not sure what the result will be."

"I think there are areas which should not have been included in this package," she continued in her assessment of the code. "They should have been considered on their own merit."

One of these is the licensing of psychologists. "It's never been done before. The representative responsible for it is a psychologist and could have been looking to his own interests," she said. "Will this enable them to collect from Blue Cross-Blue Shield?"

Rep. Symons

She also has some doubts about the physician assistant section. "It seems to me the chances for malpractice suits will increase as they only have to be in touch with physicians by radio or telephone," she said. "I'm wondering about the cost of insurance because of this and think it's very important to all physicians."

A Democrat, considered a conservative on most issues, Mrs. Symons originally ran for the office because she and her husband (now retired) did not want their three children bused out of the local school district. Although their family is grown today, her attitudes have remained constant from the days she first knocked at people's doors in her 30th district to ask for their support.

She has considerably more clout today, however, being a member of the majority part and in the top 25 of 110 representatives seniority-wise, helps.

But primarily she has earned the respect of her colleagues by standing firm, even against her party or the Governor, when she's convinced something should be done.

Pontiac honors its Doctor Furlong

By C. R. Shelton
***Special to* Michigan Medicine**

Early last fall, the Pontiac City Commission issued a resolution changing the name of its Federal Building to the Furlong Building — in honor of Harold A. Furlong, MD, one of that city's most outstanding leaders in medicine, hospital, church, civic, and cultural endeavors.

Pontiac's Mayor Wallace E. Holland states that Doctor Furlong can best be characterized as a landmark in the community and that it is only fitting that the building be named for a man who means, and has meant, so very much to so many in the area.

The building

The Furlong Building, which was built in 1912 as Pontiac's main Post Office, is a 33,000 square-foot, three-story building in excellent condition. In 1970, when a new Post Office was erected, the building became a federal office facility.

On July 1, 1978, Pontiac purchased the building for $1 from the Heritage Conservation and Recreation Service of the U.S Department of the Interior. The City of Pontiac now operates and maintains The Furlong Building as offices, a center for exhibits and public programs organized by the Pontiac Cultural Council and the Pontiac Creative Arts Center.

Many people refer to Doctor Furlong as "Doctor Pontiac," and with good reason. He started Ob-Gyn practice there in 1929, has delivered approximately 5,000 babies in the vicinity, assisted with expansions at Pontiac General Hospital, was chief of staff there, has been chief of obstetrics at both St. Joseph Mercy and Pontiac General Hospitals, and a consultant at Clinton Valley Center.

Born in what now is downtown Pontiac on Aug. 1, 1895, Doctor Furlong has lived most of his life in his hometown. His undergraduate work at Michigan State University (then Michigan Agricultural College) was interrupted in his junior year when he joined the Infantry during World War I. He was on active duty for two years, and was awarded the Congressional Medal of Honor for bravery in action during a battle in the Argonne Forest. At the time of his release from active duty he was a Second Lieutenant.

He remained in the National Guard after that and in 1940 was recalled — on a day's notice — to active duty as a Lt. Colonel in the Medical Corps. He spent two years in Lansing where he was assigned by the Adjutant General to be medical director for the Michigan Selective Service, transferred to a Desert Training Center in California, then to Ft. Riley. He spent the next year in Europe and ended his military career in 1945 as a Colonel.

War experiences

Doctor Furlong states that he was appalled at the pain and loss of life that he saw in WWI and sometime during the war decided to study medicine.

He earned an MD degree from the University of Michigan in 1924, was married the same year, and spent the next five years in Ob-Gyn postgraduate training at the University of Michigan Hospital.

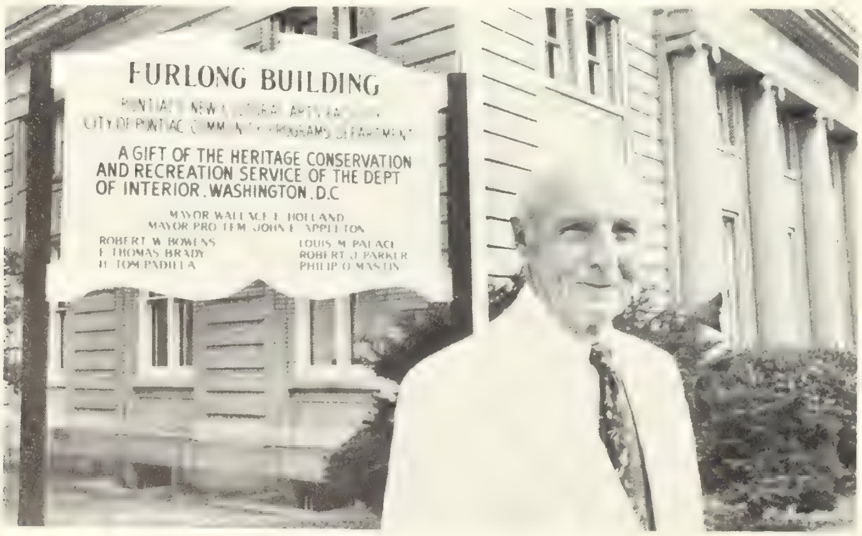
Shortly before "the crash of October, 1929," he began medical practice in Pontiac, and continued there — except for his five years of military service in WW II— until his retirement on Jan. 1, 1976.

Never one for overstating his accomplishments, Doctor Furlong says he did what he could to help his fellow Pontiac citizens during the Great Depression. Records show he served for several years as chairman of the Oakland County Red Cross and Community Chest in those difficult times, and was instrumental in providing aid to thousands.

Over the years he has given unstintingly of his time and energy to numerous people-oriented activities. He has been president of the Pontiac Board of Commerce, the Rotary Club, a member of the Oakland County Cultural Commission, and numerous other organizations. Additionally, he was the founder of the popular Pontiac Creative Arts Center.

Among the many offices he has held in medical groups are: president, Oakland County Medical Society; delegate, Michigan State Medical Society; member, MSMS Judicial Commission; and alternate delegate, American Medical Association.

In addition to his varied activities, Doctor Furlong has been a "Sunday painter" for a number of years and studied — as he puts it "erratically" — at Cranbrook and the Birmingham-Bloomfield Artist's Association. He also devotes a good deal of time to work in his greenhouse.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Doctor Furlong

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News

Doctor Brown

Doctor Payne

Doctor Silva

Doctor Walker

New officers of the Michigan Society of Pathologists are: **Robert F. Wylin, MD,** Detroit, president; **James W. Landers, MD,** Grosse Pte., president-elect; and **Theodore A. Reyman, MD,** Detroit, secretary-treasurer.

C. Allen Payne, MD, Grand Rapids, has been installed president of the Michigan Health Council for 1979. Other MSMS members elected to office in MHC are **Robert L. Tupper, MD,** Grand Rapids, as president-elect, and **Otto K. Engelke, MD,** Ann Arbor, and **E. Gifford Upjohn, MD,** Kalamazoo, were re-elected to the Board.

Frank B. Walker, MD, Grosse Pte., has been installed as president-elect of the American Society of Clinical Pathologists. Doctor Walker also represents ASCP on the AMA Specialty Council and is chairman of its Plan and Scope Committee.

William T. Unkefer, MD, Detroit, has been appointed by Governor Milliken to a 14-member task force charged with formulating policy toward legal and financial issues associated with the reduction of hospital bed capacity in Michigan.

Yvan J. Silva, MD, Detroit, has been appointed to the board of trustees of the Educational Commission for Foreign Medical Graduates. The commission administers the ECFMG examination and the Visa Qualifying Examination and also serves in the administration of the Exchange Visitors Program in liaison with the State Department and the Immigration and Naturalization Service.

"Man of the Year — 1978" is a new title Petoskey physician **Benjamin B. Blum** can add to his name. The citizens of this northern Michigan community bestowed this honor on Doctor Blum during their Annual Game Dinner and presented him with a citation.

Newly-elected president of the Section on Urology of the American Academy of Pediatrics is **Alan D. Perlmutter, MD,** Detroit. Doctor Perlmutter also, at the recent AAP Annual Meeting in Chicago, was elected trustee of the American Board of Urology, representing AAP for a six-year term. In addition to these offices, he is the new chairman of the Combined Examination Committee of the American Board of Urology and American Urological Association.

The American Society of Anesthesiologists has elected **Eli M. Brown, MD,** Detroit, first vice president of ASA. He previously has served as chairman of the ASA Peer Review Committee and held numerous other posts within the organization. Doctor Brown is a former president of Michigan Society of Anesthesiologists and the Wayne County anesthesiology society.

John G. Wiegenstein, MD, Lansing, has been appointed for a three-year term to the new 19-member Statewide Emergency Medical Services Advisory Council, to represent the physicians of Michigan. The council, created under the new public health code, will advise the Michigan Department of Public Health on training programs for emergency medical services personnel, planning, public information and education programs, and categorization of emergency services.

Grand Rapids heart surgeon **Luis Tomatis, MD,** who reported the results of his group's study of open heart surgery cost effectiveness at the MSMS Annual Scientific Meeting last fall, was recently interviewed on WOTV-Channel 8, Grand Rapids. The station offered Doctor Tomatis' interview with newswoman Jane Brierly to the NBC network, and NBC affiliates across the country now may determine if they want to use the segment locally. Early indications point to widespread use of the interview.

Governor William Milliken has appointed two physicians to the new Toxic Substance Control Commission — **Walter Meester, MD,** Grand Rapids, and **Regine Aronow, MD,** Grosse Pte. The seven-member Commission will investigate reports of irregularities involving toxic substances, examine state programs and laws dealing with dangerous chemicals, and is authorized to declare a state of emergency if it believes a toxic substance threatens the state, upon the Governor's approval.

Walter P. Work, MD, was honored by his colleagues at a special banquet during a recent two-day scientific conference for U-M otorhinolaryngology alumni. Doctor Work is retiring after 39 years as a university teacher, physician, and surgeon, with most of those years spent at the U-M Medical School. Many of those in attendance trained under Doctor Work, who served as chairman of the department from 1961 to 1977.

Thomas M. Sullivan, MD, has been appointed acting director of Lafayette Clinic, Detroit, a mental health research and training center operated by the Michigan Department of Mental Health.

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Doctor Hiscoe finds parallels in Chinese, US medicine

Michigan physicians Robert D. Burton, MD, Grand Rapids, and D. Bonta Hiscoe, MD, Lansing, here share their recent unique medical experiences. Doctor Burton traveled with an archeological expedition to the island of Mallorca off the coast of Spain, and Doctor Hiscoe joined an expedition to observe the medical care systems of Communist China.

By D. Bonta Hiscoe, MD
Lansing

Medicine in China is not all acupuncture and barefoot doctors. I learned this on a trip to the People's Republic of China in August, 1978.

Their health system is an integral part of their tight social structure. They lack technology and equipment, but there is a surprising parallelism between their approach and ours to the usual medical problems. Politics impinges on their practice of medicine, too.

Chinese medicine reflects the profound changes occurring throughout all of China today. First, their goal is to "catch up" with the West by the year 2000, in agriculture, industry, defense, science, and technology. Second, they have changed Karl Marx' teaching. "From each according to his ability and to each according to his need," to a new version, "From each according to his ability and to each according to his work."

The health system

By visiting factories, communes, an urban neighborhood, five hospitals and a convalescent home, I gained some insight into the incorporation of health care into the Chinese social system.

Eighty percent of China is rural, and here the commune is the basic social unit. Communes include 10,000 to 60,000 people, organized hierarchically from production teams at the bottom to the commune leadership at the top. They administer school and health care facilities, various agricultural projects, and even small factories. In urban centers, organized neighborhoods and larger factories serve as the social units and are responsible for educational, medical and other functions.

Health workers provide the primary care at the local level in all these units; in communes they are called barefoot doctors. These are workers themselves, often chosen by their fellows to receive the six months' training that qualifies them to practice preventive medicine, treat minor illnesses, and do some procedures, including deliveries, all under periodic supervision by visiting physicians. Problems like appendicitis, hernias, and minor fractures are referred to better-trained physicians at the commune hospitals. Still more major problems go to district hospitals in cities. We visited a couple tertiary hospitals specializing in psychiatric care, and a large convalescent home.

Medical education

Students enter medical school directly from high school after qualifying by examination. Experience as a health worker also counts. The state sends the graduate where it wants, and allows a limited number to specialize.

Notable differences

One of the key differences between their medical practice and ours is the lack of choice in China. Except for the right of a patient to refuse recommended treatment, neither patient nor doctor has any choice about who or where.

In China, two kinds of doctors are trained, those practicing primarily Chinese medicine, viz., acupuncture and herbal medicine, and those practicing primarily Western medicine.

Acupuncture is ubiquitous, and its use seems to correspond to our nonspecific use of pills. As an anesthetic it seems most effective in thyroidectomies and other surgery above the umbilicus. Epidural block provides much of their anesthesia, and some people, seeing the patient awake, mistakenly interpret this as more acupuncture.

Their practice of Western medicine

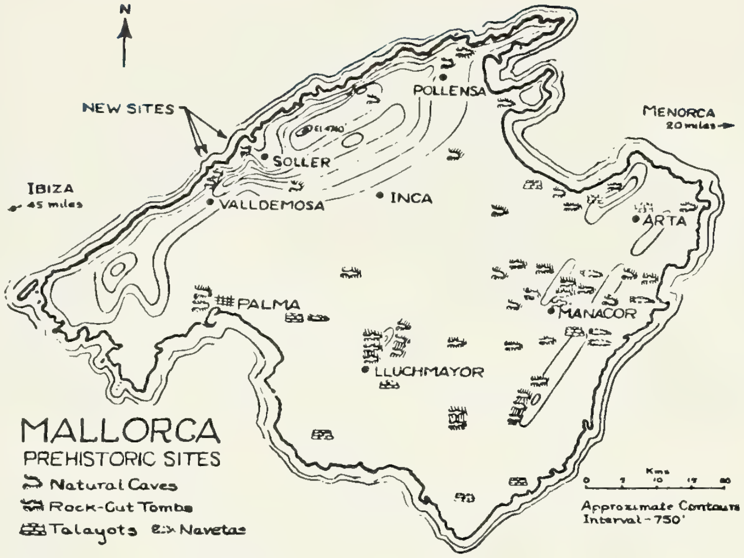
(Continued on page 136)

Dr. Hiscoe is a Lansing general surgeon and medical director of Health Central HMO.

Typical ward in Chinese hospital. Mats on bed are cool in hot, humid climate. Note mosquito netting above.

Doctor on a dig — it's Grand Rapids' Doctor Burton in Mallorca

By Robert D. Burton, MD
Grand Rapids



Boarding the night plane to Madrid on Iberia flight #952 in early September, I reflected on why I had chosen to participate in an archaeologic "dig." It could have been on the Yucatan peninsula 15 years ago or possibly several other locations when the seed was first planted. To view the mighty but now overgrown Mayan ruins in the midst of a steamy jungle and wonder about an advanced civilization existing there in 800 AD; to visit Greece and Rome and come away inspired to learn more about the grandeur and also the decline of those Golden Ages of our Western Civilization; to view the mighty-walled and heavily-fortified harbors of Rhodes and Malta and relive some of the thrills and hardships of the Crusaders — any of these may have played a part.

Armed only with desire for more knowledge and whetted by 11 months of reviewing an extensive bibliography concerning the expedition, I was on my way. My baggage consisted of a summer-weight sleeping bag and an overstuffed Air Force duffel bag filled with the suggested work clothes — mostly khaki!

We took a quick plane transfer from Madrid to Mallorca and suddenly the scene became the blue Mediterranean Sea and a rolling country terrain consisting mainly of lemon trees, almond orchards and twisted ancient olive trees, many of which had been planted by the Romans in 123 BC. At the Palma airport the plane was met by the principal archaeologist, William Waldren from Oxford University, along with the rest of the professional staff representing University of Utrecht and also Cambridge University. Leaving this densely populated city of 275,000 we were soon heading into the mountainous north coast of Majorca to the tiny village of Deya. En route we passed through scenic Valldemosa (see map) a town now capitalizing on the fact that Polish Composer Frederic Chopin and French authoress George Sand spend the fall and winter there of 1838 having a tempestuous love affair. Chopin composed his two polonnaises here.

Our living quarters were just down the mountain along the road to Deya where a combination study center and museum had been constructed by Waldren and his staff. An excellent library was present and almost every night after dinner a formal lecture was given by one of the staff.

Our team consisted of 19 persons of various archaeologic expertise. The common thread seemed to be a desire to learn more about previous civilizations in that area of the world and also to participate first-hand in uncovering history.

Half of the team spent three days in the laboratory while the other half of the team was involved in the field work.

A first-day orientation or "shakedown" trip to the excavation sites shook up some of the team members when they saw one cave entrance measuring only 18 inches in width. The entrance was key-hole-shaped with a rope ladder leading vertically down 40 feet into a candle-lit chamber. The walls of this chamber had been scientifically dated at 75,000 BC.

This was the cave of Son Muleta and has proven to be one of the most productive sources of pre-historic animal and human remains in the entire Mediterranean area. With the deceptive key-hole entrance the cave had become a natural trap to the unwary for thousands of years.

Our second site of excavation was that of a rock shelter called Son Matge. This huge natural concavity served a number of purposes through the centuries. It was a home to tribes of pre-historic man; it became a kind of corral for pre-historic gazelle-antelope called Myotragus; and finally became a burial ground for a Bronze Age community during 1400-700 BC. The cave has been a treasure chest for recovery of jewelry,

(Continued on page 150)

Doctor Burton is an otolaryngologist, an alternate delegate to the AMA, and a member of the MSMS Committee on State Legislation and Regulation.

is severely handicapped by lack of modern buildings and equipment. Without tile and ceramic surfaces, they cannot keep the hospitals spotless. The large open wards are barren except for the iron rail beds. In the commune hospitals, the delivery and operating rooms and the X-ray equipment are, frankly, crude. Even in their better hospitals there are no anesthesia machines; only suction is built into the wall. A dearth of angiography means very little vascular surgery. Lack of amino acids precludes hyperalimentation. Intensive care, neonatal intensive care units and monitors are conspicuously absent.

A private conference with the chief of surgery at the prestigious Peking Union Medical Hospital revealed that the spectrum of diseases in China is quite different from ours. The Chinese have more carcinomas of the stomach and esophagus, and fewer carcinomas of the lungs than we do. Their problem with intrahepatic gallstones is quite unlike anything here. They share with us the usual surgical problems — appendectomies, cholecystectomies, mastectomies and gastrectomies. With minor exceptions they handle these much as we do.

Politics in medicine

The Cultural Revolution disrupted the practice of medicine by shutting down medical schools and instituting complete egalitarianism throughout the profession. No distinction remained in surgical privileges between a man with one year's training and a man with many years of training and experience. Restoration of training programs followed the deposition of the Gang of Four and now political pressure favors a more traditional approach.

Summary

In medicine as in their entire national policy, the Chinese are suddenly interested in sharing with the rest of the world. To quote a hospital administrator at one of our briefings, "Chairman Hua is bringing emancipation to the people. Now all the staff is striving to follow the goals of Lenin, Chairman Hua and the Eleventh Conference of the Communist Party, deepening the struggle against the Gang of Four. Efforts are being made to increase research in medicine and pharmacology to create a new medicine. We are making a new long march towards modernization by the year 2000 A.D."

Doctor Hiscoe and Shanghai surgeon.

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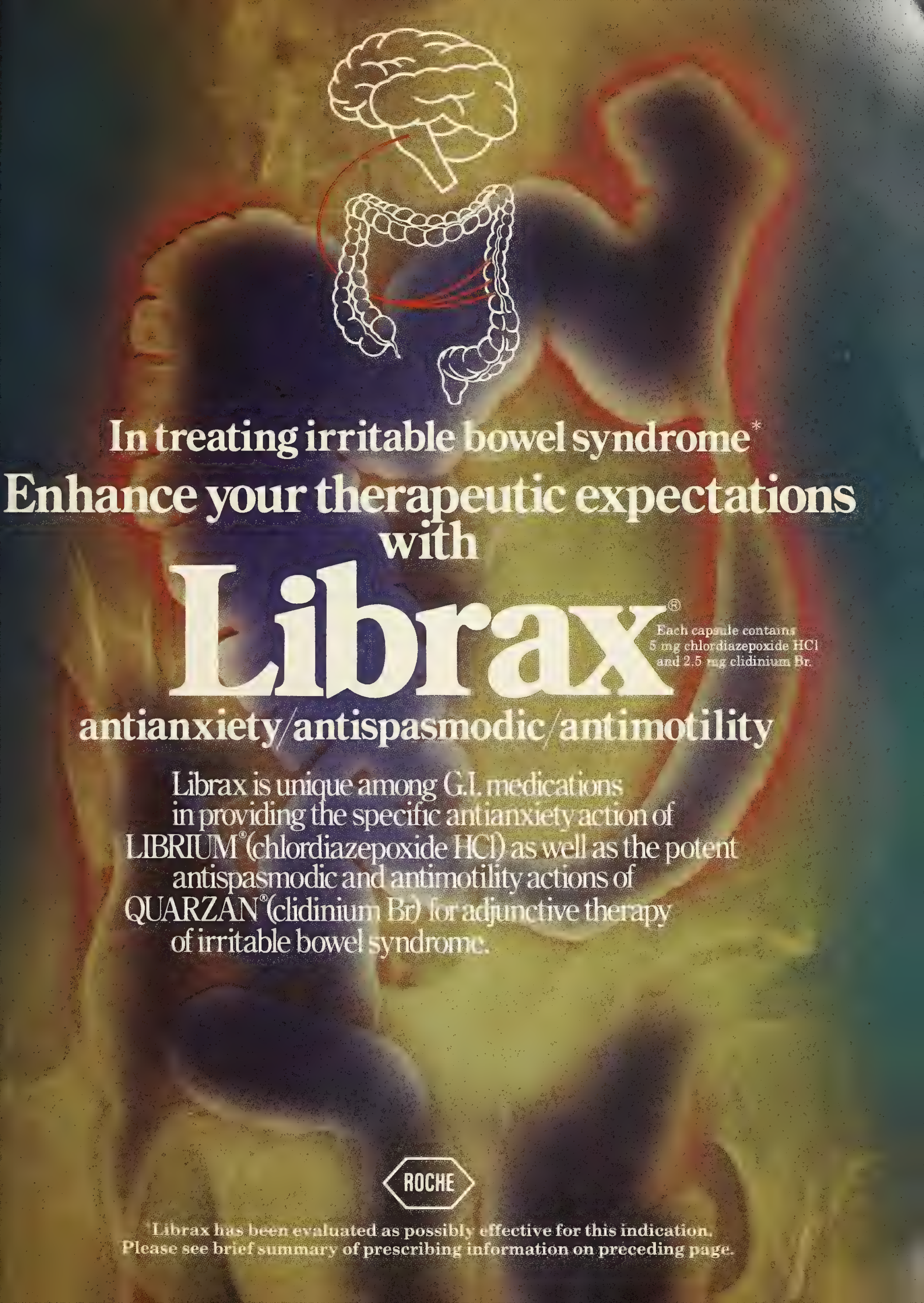

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Category I courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: March 11-16, Boyne Mountain Midwinter Cancer Symposium. Location: Boyne Mountain, Boyne Falls. **Sponsore:** Wayne State University School of Medicine, Dept. of Oncology. **For:** General practitioners, family practitioners, surgeons, radiotherapists, pathologists and oncologists. **Cost:** $175. **Contact:** Div. of Continuing Medical Education, Wayne State University School of Medicine, 1206 Scott Hall, 540 E. Canfield, Detroit, 313/577-1180. **Approved for:** 29 hours of Category I Credit.

Date: March 14, Kidney Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: March 14-16, Advances in Pediatrics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians. **Cost:** $180. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: March 21, Detection and Primary Care of Breast Cancer. Location: Kalamazoo Hilton Inn. **Sponsor:** Oncology Sections, Borgess and Bronson Hospitals, Kalamazoo. **Cost:** $50 in advance, or $60 on the registration day. **Contact:** C. L. Zeller, Jr., MD, Southwestern Michigan Health Education Center, 252 East Lovell St., Kalamazoo 49007. 616/383-6489. **Approved for:** 7 hours of Category I Credit.

Date: March 21, Early Breast Cancer. Location: Kalamazoo Center Inn, Kalamazoo. **Sponsor:** Bronson and Borgess Hospitals Oncology Section. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All Interested Physicians. **Cost** $50. **Contact:** Leo Zelkowitz, MD, Bronson Hospital, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: March 22-23, General Surgery. Location: Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Surgeons. **Cost:** $145. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 15 hours of Category I Credit.

Date: March 23-24, XII Annual Cancer Symposium. Location: Green Auditorium, 3rd Floor Scott Hall, Wayne State University School of Medicine Campus. **Sponsor:** Wayne State University School of Medicine, Dept. of Oncology. **For:** General practitioners, surgeons, radiotherapists, pathologists and oncologists. **Cost:** $75. **Contact:** Div. of Continuing Medical Education, Wayne State University School of Medicine, 1206 Scott Hall, 540 E. Canfield, Detroit, 313/577-1180. **Approved for:** 9.5 hours of Category I Credit.

Date: March 24, A Day of Clinical Gastroenterology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Family physicians, internists. **Cost:** $70. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: March 24, Psychotherapy with Children of Divorce. Location: Somerset Inn, Big Beaver Road, Troy. **Sponsor:** The Maple Clinic, Inc. **Cost:** $40. **Contact:** The Maple Clinic, Inc., 950 E. Maple, Birmingham 48011, 313/646-6659. **Approved for:** 5 hours of Category I Credit.

Date: March 28-30, Staff Development: A Team Approach in Treatment Settings. Location: U-M, Ann Arbor. **Sponsor:** Institute of Gerontology, U-M/WSU. **Cost:** $95. **Contact:** Dorothy Coons, Continuing Education Program, Box N, Institute of Gerontology, 520 E. Liberty, Ann Arbor 48109. 313/764-3493. **Approved for:** 16 hours of Category I Credit.

Date: March 30, Brain, Lung, and Trauma. Location: Kalamazoo Valley Community College. **Sponsor:** Bronson Methodist Hospital. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Emergency room physicians, neurosurgeons, pulmonary medicine specialists, family physicians. **Cost:** $30. **Contact:** Educational Services, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo 49006. Phone: 616/383-6405. **Approved for:** 7 hours of Category I Credit.

Date: March 31, Acid-base/blood gas workshop. Location: McGregor Memorial Conference Center, Wayne State University, Detroit. **Sponsor:** WSU School of Medicine Division of Continuing Medical Education. **Cost:** $25. **Contact:** WSU School of Medicine Division of Continuing Medical Education, 1206 Scott Hall, 540 E. Canfield, Detroit 48201 (313/577-1180). **Approved for:** 6.5 hours of Category I Credit.

Date: April 2-27, Surgical Anatomical Review. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **For:** Surgeons. **Cost:** $425. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 120 hours of Category I Credit.

Date: April 6, Seminar on the care of mother and infant with jaundice. Location: E. W. Sparrow Hospital, Lansing. **Sponsors:** Department of Neonatology, Sparrow Hospital, and departments of pediatrics and human development, Michigan State University College of Human Medicine. **Contact:** Jean Machtel, Continuing Medical Education Coordinator, Sparrow Hospital, Lansing (517/487-2790). **Approved for:** 3 hours of Category I Credit.

Date: April 6-7, Medical and Surgical Problems in Infants, Children and Adolescents. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $150. **Contact:** Henry Ford Hospital, Office of Medical Education, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 15 hours of Category I Credit.

Date: April 6-7, The Physical and Mental Mobilization of the Myelodysplastic Patient. Location: Sheraton Inn, Kalamazoo. **Sponsor:** Michigan Myelodysplasia Association. **For:** Orthopedists, pediatricians, neurologists, urologists, ophthalmologists. **Cost:** $20. **Contact:** Stryker Center, % Southwestern Michigan Myelodysplasia Clinic, 1521 Gull Road, Kalamazoo 49001, 616/383-4839. **Approved for:** 10.5 hours of Category I Credit.

Date: April 6-7, Ischemic Cerebrovascular Disease. Location: Detroit Medical Center and Detroit Plaza Hotel in the Renaissance Center. **Sponsor:** Wayne State University School of Medicine, Dept. of Neurology and Neurosurgery. **Cost:** $120. **Contact:** Wayne State University School of Medicine, Div. of CME, 1206 Scott Hall, 540 E. Canfield, Detroit 48201, 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: April 12, Conference on Medical Aspects of Sports. Location: Towsley Center, Ann Arbor. **Sponsor:** MSMS. **Contact:** Mert Scholten, MSMS, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME. 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: April 16-June 18, Pediatric Seminar IV. Location: St. John Hospital Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $200. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 20 hours of Category I Credit.

Date: April 19, 20, 1979, Michigan Chapter American College of Surgeons. Location: Ann Arbor, Rackham Building. **Sponsor:** University of Michigan Medical Center. **For:** Surgeons. **Cost:** No charge. **Contact:** John H. McLaughlin, MD, 604 N. Woodward, Birmingham, Michigan. **Approved for:** 12 hours of Category I Credit.

Date: April 20, "Cardiac Rehabilitation and Exercise Testing Symposium." Location: Borgess Hospital Auditorium, Kalamazoo. **Sponsors:** Cardiac Rehabilitation Center, Borgess Hospital; Southwestern Michigan Area Health Education Center; Michigan Heart Association, and American Academy of Family Physicians. **For:** All Interested Physicians. **Cost:** $50. **Contact:** Enrique Leguizamon, MD, Cardiac Rehabilitation Center, Borgess Hospital, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 7 hours of Category I Credit.

Date: April 22, 21st Annual Spring Clinic, "Gastroenterology." Location: Valley View — Shepherd. **Sponsor:** Central Michigan Community Hospital, Mt. Pleasant. **Co-Sponsor:** Gratiot Community Hospital, Alma. **Contact:** Frank D. Johnson, MD, Director, Continuing Medical Education, CMCH, 1221 S. Drive, Mt. Pleasant 48858, 773-7941; or Mary Jane Conkright, Medical Staff Secretary, 773-7941, Ext. 190 CMCH. **Approved for:** 8 hours of Category I Credit.

Date: April 23-27, Cardiology Tutorial Program. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital, Office of Continuing Education. **For:** General practitioners and internists. **Cost:** $300. **Contact:** Sidney Goldstein, MD, Div. of Cardiovascular Medicine, 313/876-2727. **Approved for:** 40 hours of Category I Credit.

Date: April 24, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: April 26-28, Eighth Annual Critical Care Symposium. Location: Wayne County Medical Society headquarters, 1010 Antietam, Detroit. **Sponsor:** Department of Surgery, Wayne State University School of Medicine, and Michigan Committee on Trauma, American College of Surgeons. **Cost:** $95. **Contact:** Robert F. Wilson, MD, Department of Surgery, Wayne State University School of Medicine, 540 E. Canfield, Detroit 48201. **Approved for:** 15 hours of Category I Credit.

Date: April 28, Decision Making in Difficult Cardiac Patients. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $70. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: May 2, "Practical Management of Seizures." Location: Borgess Hospital Auditorium, Kalamazoo. **Sponsor:** Neurology Department, Borgess Hospital. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All Interested Parties. **Cost:** $40. **Contact:** Charles L. Zeller, Jr., MD, Director Continuing Medical Education, Southwestern Michigan Area Health Education Center, 252 East Lovell Street, Room 364, Kalamazoo 49007, 616/383-6489. **Approved for:** 7 hours of Category I Credit.

Date: May 5, Spring Northern Michigan Perinatal Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Northern Michigan Hospitals, Inc., Petoskey. **For:** Pediatricians, obstetricians, family practitioners. **Cost:** $30. **Contact:** Rochelle Igrisan, RN, Perinatal Nurse-Educator, Northern Michigan Hospitals, Inc., Petoskey 49770, 616/374-7373 or 616/347-5000. **Approved for:** 6 hours of Category I Credit.

Date: May 8, Human Values and Health Care. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **Cost:** $50. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: May 10-11, Ophthalmology Conference. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: May 10-11, Heart Days. Location: Kalamazoo Center, Kalamazoo. **Sponsor:** Michigan Heart Association. **For:** Physicians, nurses, therapists and all allied health personnel. **Cost:** Physicians: $50 (two days) or $30 (one day). **Contact:** Michigan Heart Association, P.O. Box LV-160, Southfield 48076. **Approved for:** 10 hours of Category I Credit.

Date: May 11, 12, Common E.N.T. Problems. Location: Radisson-Cadillac Hotel, 1114 Washington Blvd. at Michigan Ave., Detroit 48231, 313/256-8000. **Sponsor:** Wayne State University School of Medicine, Dept. of Otolaryngology. **For:** Primary care physicians. **Cost:** $120. **Contact:** Wayne State University School of Medicine, Div. of CME, 540 E. Canfield, 1206 Scott Hall, Detroit 48201, 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: May 12, Michigan Society of Pathologists May Seminar, "Mucosal Biopsy of the Gastrointestinal Tract." Location: Hurley Hospital, Flint. **Sponsor:** Mt. Carmel Mercy Hospital, Dept. of Pathology. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit, MI. **Approved for:** 3 hours of Category I Credit.

Date: May 14-18, Head and Neck Oncology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otorhinolaryngologists, surgeons. **Cost:** $500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

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Date: May 18, Infectious Diseases Symposium. Location: Grand Rapids. **Sponsor:** Butterworth Hospital, Grand Rapids. **Contact:** Butterworth Hospital Medical Education Office, 616/774-1835. **Approved for:** 7 hours of Category I Credit.

Date: May 21-25, Advances in Internal Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Internists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: May 21-25, Principles of Milieu Practice: Working with the Elderly in Treatment Settings. Location: Institute of Gerontology and School of Education, The University of Michigan/University of Michigan Medical School. **Sponsor:** U-M. **Cost:** $140. **Contact:** Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4102. **Approved for:** 30 hours of Category I Credit.

Date: May 23, Rheumatology Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: May 23, "Orthopaedic Problems For The Non-Orthopaedist." Location: Kalamazoo Hilton Inn. **Sponsor:** Orthopaedic Section, Bronson and Borgess Hospitals, Kalamazoo. **Co-Sponsor:** Southwestern Michigan Area Health Education Center, 252 East Lovell Street, Kalamazoo. **For:** All Interested Physicians. **Cost:** $40 Advance Registration. **Contact:** Charles L. Zeller, Jr., MD, director, Continuing Medical Education, Southwestern Michigan Area Health Education Center, 252 East Lovell Street, Room 364, Kalamazoo 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 24-26, Workshop in Advanced Cardiac Life Support. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $175. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 20 hours of Category I Credit.

Date: June 7-8, Blood Banking. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $90. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: June 7, 8, 9, Annual Keyport Trauma Symposium. Location: Otsego Ski Club, Gaylord. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons. **Cost:** $25. **Contact:** B. E. Henig, MD, 308 Michigan Ave., Grayling 49738, 517/348-6611. **Approved for:** 12 hours of Category I Credit.

Date: June 11-12, Issues in Hospice Care for the Elderly: A Forum. Location: U-M. **Sponsor:** Institute of Gerontology, The University of Michigan; The University of Michigan Medical School; and the United Way of Washtenaw County. **Cost:** $75. **Contact:** Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4102. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 10-12, ECG Interpretation and Arrhythmia Management. Location: Shanty Creek Hilton, Bellaire. **Sponsor:** International Medical Education Corporation. **Cost:** $202. **Contact:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. 800/525-8646 Toll free. **Approved for:** 15 hours of Category I Credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

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Muskegon doctors' recruiting results in 28 new MDs in two years!

By Robert C. Packer, MD
Muskegon

The development of programs designed to attract new physicians to the Muskegon area has been a continuing activity of the Muskegon County Medical Society through its Physician Procurement Committee.

This effort has met with varying degrees of success and the results haven't always been spectacular.

However, in the past two years, 28 new physicians began practice in Muskegon County. This increase is at least twice that of any two-year period in recent history and perhaps is greater than at any period in the past.

Coincidentally the recruitment activities had been increased in the preceding two to three years (for reasons to follow) and it would be convenient to assume that the influx of new physicians was a direct result of those stepped-up efforts to attract new physicians. An analysis of this group was done to attempt to document the effectiveness of those recruitment activities. The primary means of reaching prospective new physicians have been the usual ones of placing advertisements in various journals including the *JAMA*, *New England Journal of Medicine*, and specialty journals; and by listing notices with the Michigan Health Council and with various postgraduate training programs.

In addition, and in conjunction with the Muskegon Medical Foundation, the Muskegon County Medical Society made funds available to defray a portion of the expenses of those prospective physicians coming to pay site visits and, in some cases, loans were arranged with the agreement that the recipient would spend some period of time practicing in Muskegon as well as repaying the loan.

Individual efforts were made by those physicians and groups of physicians desiring associates in their practices, and area hospitals also attempted to recruit physicians which would allow them to provide new services or to augment existing ones.

The most frequent negative factors which discouraged new physicians when they considered locating in the Muskegon area included limited cultural and academic opportunities, belief that the economy was weak, the absence of house staff and "academic medicine," climatologic factors of heavy snowfall and scarcity of winter sunshine, and of major importance, the lack of desirable office space in which to locate.

Recruiting activities increased in 1975 with the completion of the first of two medical office buildings located adjacent to major hospitals in the area. The second was completed early this year. The other negative factors appeared to be less important when prime available locations could be guaranteed to prospective physicians with favorable rental arrangements in the first few months of occupancy.

In 1977 an intensive program to contact available physicians was carried out. We sent notices to eight large training centers in the Midwest requesting that all training program directors inform their residents of the opportunities in Muskegon. We mailed nearly 800 personal letters to Midwest physicians in the last two years of their residency describing the advantages of practice in Muskegon.

The relationship of these recruiting activities to the recent influx of new physicians to the area is interesting. In the past two years, the number of active members in the Muskegon County Medical Society

(Continued on page 146)

Doctor Packer is immediate past president of the Muskegon County Medical Society, and presided at the time of the influx of physicians he describes.

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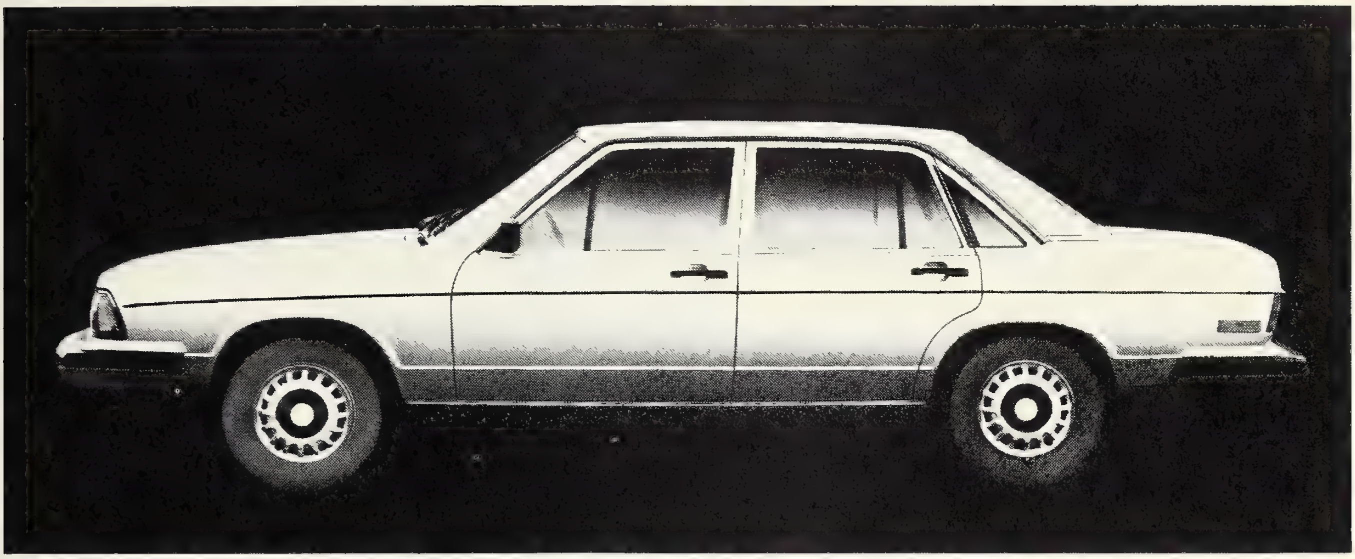

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has increased by more than 20 percent, from 112 in 1976 to 138 at present. These MDs, plus 54 DOs, provide the medical care for approximately 165,000 people in Muskegon County. In the last census (1970) there were 113 MDs for a county population of 157,425. (Figures for current population were taken from the 1977 City Directory and are not official.)

A limited study including a short questionnaire was done on the 28 new physicians beginning practice in 1977 (10) and 1978 (18). Twenty-seven of the 28 responded. Data obtained is both interesting and revealing.

1. The average age is 34 years. Most are between 28 and 40 with the exception of two who are 46 and 54 years of age.

2. All but three are native born Americans. Those exceptions are one physician each from India, New Zealand and the Philippine Islands. Two of these three have American specialty training.

3. Specialties include:

Internal Medicine	3
Cardiology	2
Family Practice	2
OB-GYN	2
Orthopedics	2
Pediatrics	2
Urology	2
Anesthesia	1
Cardiac surgery	1
Emergency Room Med.	1
ENT	1
General surgery	1
Neurology	1
Neurosurgery	1
Ophthalmology (retina)	1
Pathology	1
Radiology	1
Thoracic surgery	1
Vascular surgery	1
	27

4. Of those 24 born in the United States, 14 list their home state as Michigan. Other states represented are Illinois, Iowa, Nebraska, California, Pennsylvania, Oregon, Tennessee, Maryland and New Hampshire.

5. Of the 27 physicians, 18, or ⅔, had their specialty training in the Midwest (8 in Michigan).

6. Seventy-five percent of the total stated Muskegon was their first choice of location, the others indicating they would have located in another area if their specialty had been in demand.

7. Fifteen of the 27 located in Muskegon because of the combination of a good practice opportunity and a desirable place to live, with strong emphasis on a high quality medical community with outstanding outdoor recreational activities. Of the remaining 12 in the group, 10 placed primary emphasis on the practice opportunity only as the determining factor.

8. Only nine of 27, or ⅓, were made aware of the practice opportunity in Muskegon by advertisement, letter or placement groups including the Michigan Health Council. Eight of the new physicians had previously vacationed or lived in the area and the majority of those remaining made or received direct contact with area physicians.

Conclusion

The addition of 28 new practicing physicians covering a wide range of specialties to the medical community of Muskegon County in a period of two years has been studied. This influx of new medical talent is of inestimable value to the residents of the area in terms of new medical services and improved availability of physician service.

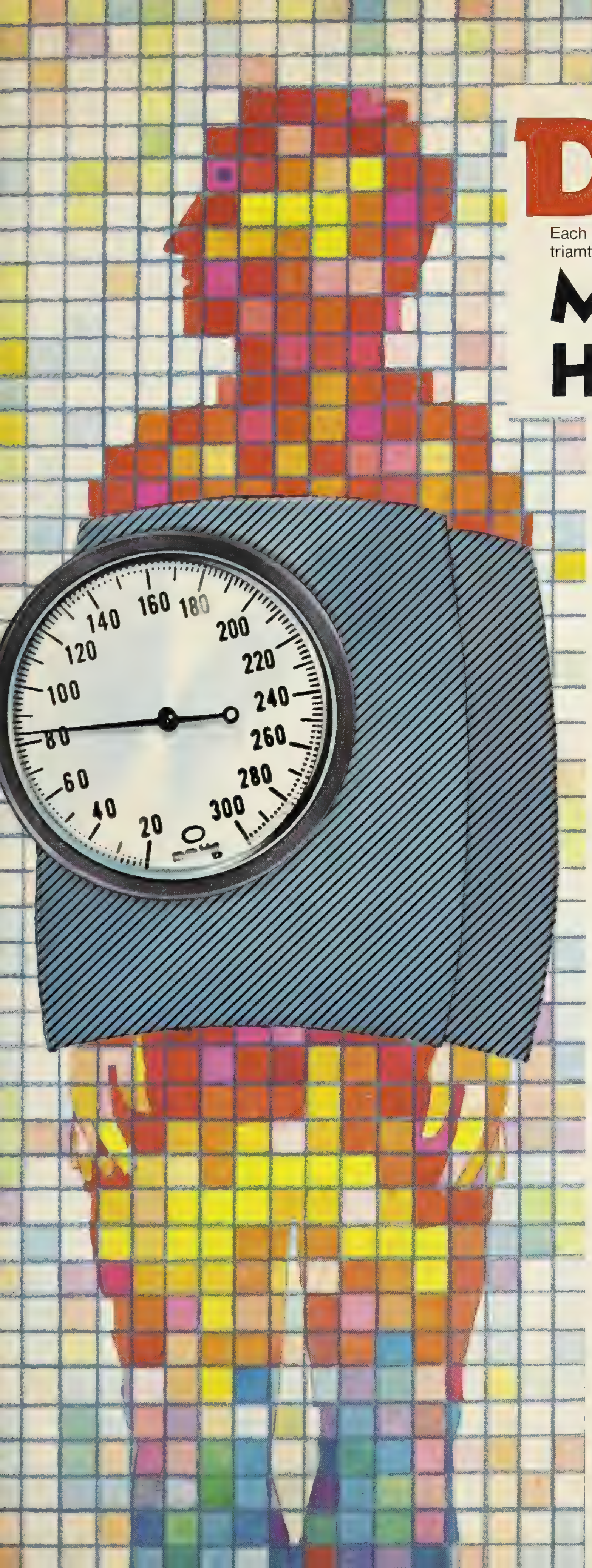
In this group of physicians, the traditional methods of recruiting using journal advertisement placement services and training center contact appear to be of low productivity compared to the factors of personal physician contact and the prospective physicians' familiarity with the area in question. In general, the new physician in Muskegon is 34 years of age and in the first year of private practice after specialty training. He was born in Michigan and received his specialty training in the Midwest.

Doctor Packer

His decision to locate in Muskegon was based on his desire to live in a small metropolitan area having easy access to larger cities and offering outstanding outdoor recreational activities and high quality medical practice.

He either contacted or was contacted by a physician or group of physicians practicing in the area to determine the opportunities available to him. It is unlikely the initial contact was prompted by a formal recruiting effort. When he personally visited the area he found available office space in prime locations, physicians welcoming him to the community and individuals offering assistance in matters important in initiating a medical practice.

A 1978 study of medical manpower done by the Michigan Health Council and commissioned by the Muskegon County Medical Society indicates that in the short period of two years, nearly all of the areas of physician shortage in Muskegon County have been filled. Because of this, no active recruiting is being done other than in the fields of psychiatry and allergy at the present time. The county medical society is presently considering methods of coordinating all physician recruitment on a county-wide level to avoid problems of over-supply or undersupply of physicians in the future.



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Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

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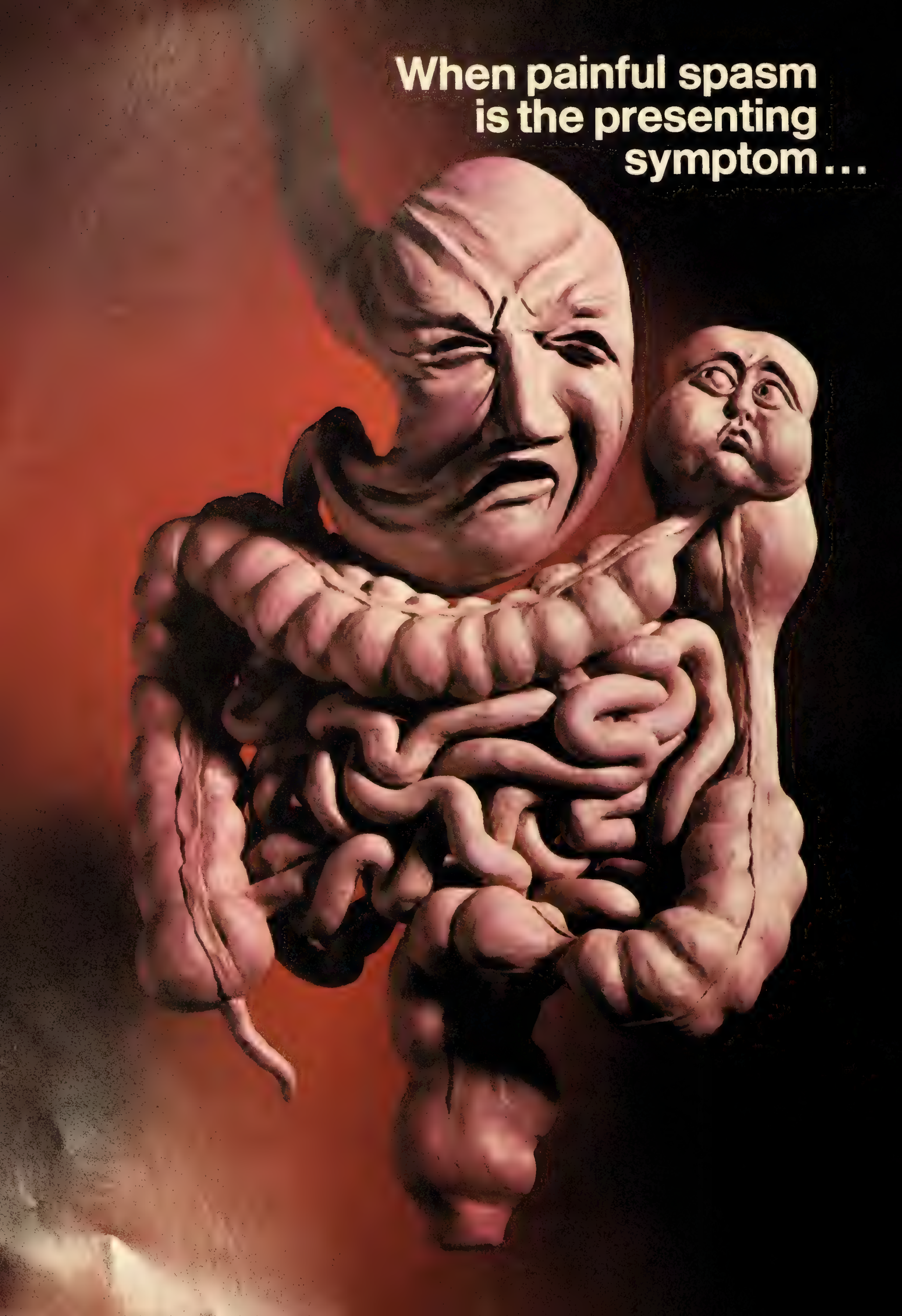
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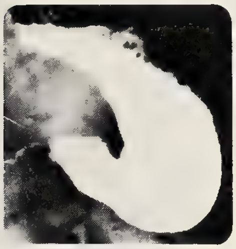
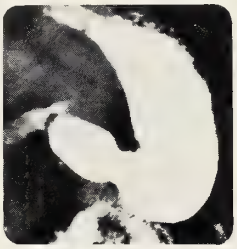
. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



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See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®
(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS
For use in the treatment of infant colic (syrup)
Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with. Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition
Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia; urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness; drowsiness, weakness; dizziness, insomnia, nausea; vomiting; impotence, suppression of lactation; constipation; bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs
Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily. *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water) Bentyl 20 mg.: *Adults* 1 tablet three or four times daily Bentyl Injection: *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used
Product Information as of October, 1978

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U S A

Merrell
MERRELL NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
[illegible] U S A

DOCTOR ON A DIG/*continued*

pottery, weapons, tools and skeletal remains of prehistoric man and animals.

The third excavation was carried out in the open field of a wealthy landowner's sprawling estate. We had the good fortune to enter and survey an entirely unexplored area that had been inhabited by a Bronze Age civilization known as the Talayotic Culture. This culture existed from 1400 BC until 800 BC and their distinctive trait was the construction of hugh megalithic towers called talayots. These resemble the megalithic structures at Stonehenge in England. To uncover these ancient structures required the use of rakes, saws, and axes due to the fact that the overgrowth of olive tree roots and thorn-covered vines entirely enveloped these formations.

As a medically trained member of the "dig" team, I was most welcome. Not only is a physician valuable to the group for readily-available medical care and advice, but also for his training in basic science. Osteology — the classification and identification of bones — is an everyday activity; medical pathology including examination and evaluation of osteosarcomas, osteoarthritis, and healed fractures due to combat and injury were often identifiable in museum specimens.

Special investigative laboratory projects in related medical subjects were encouraged and readily available. Practical public health problems of disease prevention and control, sanitation advice, and other related problems that such a group encounters are all part of a physician's mental make up and background.

Such a working vacation is pleasurable as well as mentally stimulating. If swimming in the azure waters of the Mediterranean Sea after a dusty day's work, if seeing and hearing wandering gypsy musicians and dancers spontaneously perform in local cafes after the dinner hour, if sipping fresh expresso coffee while watching the early morning sunlight illuminate the mountain peaks — if these pleasures along with the thrill of primary discovery don't excite you then such a trip is not for you.

"Breathes there a man with soul so dead . . .?" BON VOYAGE!!!!

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AIR FORCE. HEALTH CARE AT ITS BEST.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Anan A. Abdelrahman, MD (OBG)
525 N. Milford Rd. #200
Milford 48042

Reynaldo B. Arceno, MD (GP)
240 Visger Rd.
River Rouge 48218

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Henry Ford Hosp.
Detroit 48202

Dietrich P. Blumer, MD (P)
Henry Ford Hosp.
Detroit 48202

Enrique M. Boquin, MD (IM)
2011 Middlebelt Rd.
Garden City 48135

Kenneth W. Byers, MD (IM)
1579 W. Big Beaver Rd. B
Troy 48084

William M. Capina, MD (AN)
1232 N. Michigan
Saginaw 48602

Arnold M. Cohn, MD (OTO)
3740 John R
Detroit 48201

Maria Corondan, MD (GP)
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St. Clair Shores 48082

Norma C. Derro, MD (PD)
18250 S. Drive #96
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Detroit 48202

Evelyn J. Fisher, MD (IM/ID)
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Phillip Friedman, MD (NS)
17515 W. Nine Mile Rd. #580
Southfield 48075

Vinaya K. Gavini, MD (PD)
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William S. Gross, MD (GS)
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Wyandotte 48192

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Auxilians' Legislative Day set April 10 in Lansing

Mrs. McGillicuddy

by Anita Yannitelli
Communications Chairman

One of the most cooperative ventures between MSMS and its auxiliary is the annual Legislative Day, to be held this year on April 10 at Kellogg Center, East Lansing.

This is the 11th year MSMS and MSMS-A have worked together to provide auxilians with an insight into governmental affairs. Bruce Ambrose, MSMS Government Relations Manager, has worked closely with Mrs. James McGillicuddy, MSMS-A legislative chairman. The MSMS-A president, Mrs. Edward Weddon, and other members also are involved in the planning, execution and promotion of the increasingly-popular event.

Bruce Ambrose will head the program and will give current news regarding pending legislation as it concerns the Michigan physician.

Sherry Wellman, MSMS government agency liaison, will speak on health planning in Michigan. Ms. Wellman works with the Statewide Health Coordinating Council, and the Bureau of Medical Assistance, which administrates the Medicaid program, as well as other government agencies.

Tony Riker, JD, an attorney from the AMA office on State Legislation, will give a nationwide overview of legislation which is under consideration or recently enacted in all states. Riker, enthusiastic and energetic, is an interesting and well-informed speaker.

Edward Pierce, MD will speak on "Hometown Politics." Doctor Pierce, an Ann Arbor Democrat, became the only physician in the state legislature when elected in November. A 1959 graduate of the University of Michigan, Doctor Pierce is expected to be a leader in health-related issues arising in the Senate. He has recently been appointed chairman of the Senate Health, Social Services and Retirement Committee.

Louis E. Heideman, MD, MSMS president, will offer review and comments.

Luncheon will be served in the Big Ten Room for auxilians and state legislators. Members are asked to invite individual representatives or senators to the luncheon.

Guests and spouses are welcome to attend the session. Reservations may be made with Helen Schulte, MSMS-A Coordinator.

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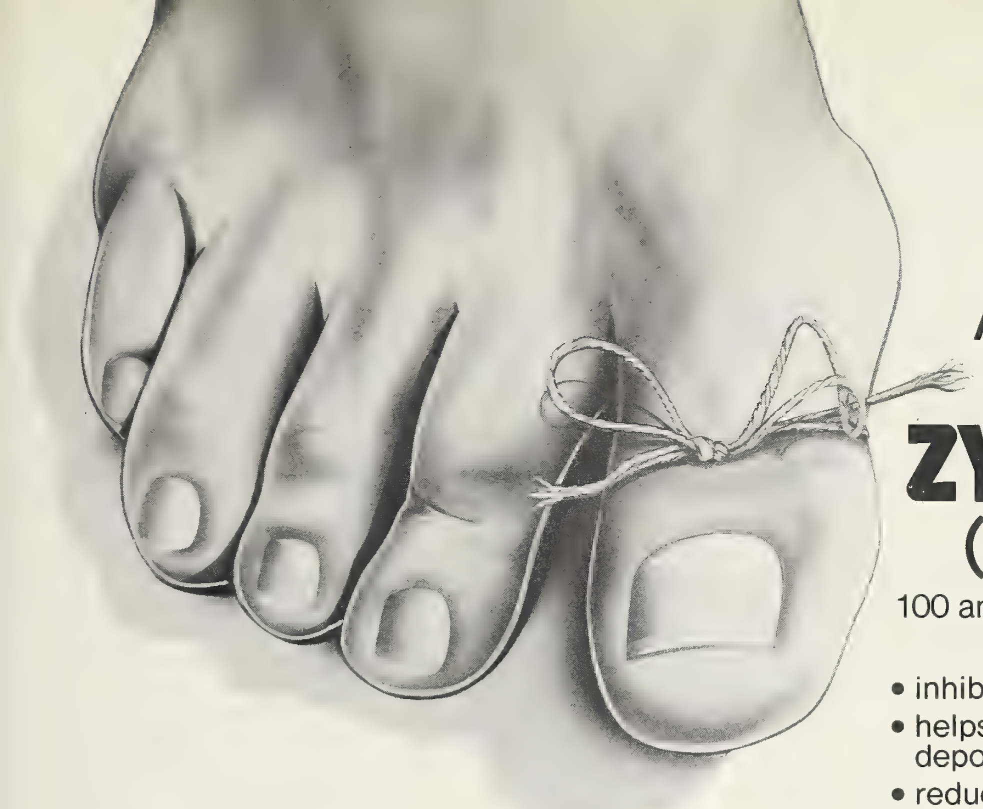

A reminder

ZYLOPRIM®
(allopurinol)
100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)

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Meetings

April 10 — MSMS Auxiliary Legislative Day, Kellogg Center, East Lansing, contact: Helen Schulte, MSMS headquarters.

April 12 — MSMS Conference on Medical Aspects of Organized Athletics, Towsley Center, Ann Arbor, contact: Mert Scholten, MSMS headquarters.

April 26-29 — Medical Assistants State Convention, Lansing, contact: Helen Schulte, MSMS headquarters.

May 4-6 — MSMS Auxiliary Annual Convention, Sheraton Inn, Kalamazoo, contact: Helen Schulte, MSMS headquarters.

May 4-5-6 — MSMS House of Delegates, Kalamazoo Center Inn, Kalamazoo, contact: Richard Campau, MSMS headquarters.

July 5-8 — MSMS Council, Birchwood Farm Golf & Country Club, Harbor Springs, contact: Warren Tryloff, MSMS headquarters.

July 22-26 — AMA Annual Meeting, Chicago Marriott Hotel, contact: AMA headquarters, 312/751-6000.

Sept. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters: 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other Meetings

March 22-23 — Program on Hospital Accreditation Standards (PHAS), Bellaire, contact: Michigan Hospital Association, 2213 E. Grand River Ave., Lansing, 48912. 517/484-7441.

April 16-20 — Family Practice Review, University of Michigan.

June 15-19 — Association for Behavior Analysis 5th Annual Convention, Hyatt Regency Dearborn, contact: ABA Program Committee, Dept. of Psychology, Western Michigan University, Kalamazoo 49008. 616/383-1629.

July 28-Aug. 1 — MAFP Annual Meeting, Traverse City.

Tenuate® ⓒⅣ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M : A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

8-3921 (Y587A)

Whether overweight is a complicating factor... or just uncomplicated overweight.

Tenuate® Dospan® Ⓒ IV (diethylpropion hydrochloride NF)

75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

Merrell

For prescribing information see opposite page

The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions.
However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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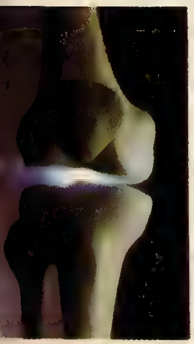
RHEUMATOLOG



Motrin 400 mg TABLETS
ibuprofen, Upjohn

The confidence that comes from experience—one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

J-6857-4

The confidence that comes from experience—
one more reason to prescribe

Motrin 400 mg TABLETS
ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS)

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin* Bleeding has been reported in patients taking Motrin and coumarin

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)	
Bottles of 60	NDC 0009-0733-01
Bottles of 500	NDC 0009-0733-02
Motrin Tablets, 400 mg (orange)	
Bottles of 60	NDC 0009-0750-01
Bottles of 500	NDC 0009-0750-02
Unit-dose package of 100	NDC 0009-0750-06
Unit of Use bottles of 120	NDC 0009-0750-26

Caution. Federal law prohibits dispensing without prescription

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WCMS installation

Doctor France: New emphasis needed on primary care; Doctor Gagliardi: MDs must be involved in broad issues

The development of major medical centers and a re-emphasis on the role of the primary physician are required now in the light of the past 40 years' medical advances.

So observed C. Jackson France, MD, Detroit-area surgeon, as he was installed Jan. 8 as president of the Wayne County Medical Society. Doctor France also is a member of the MSMS Council.

"These advances which have brought the American public the finest health care in the world have, in themselves, brought major problems," he said. "Modern scientific medicine requires modern hospital facilities and often expensive equipment.

"The modern scientifically-trained physician tends to practice where such facilities are available, creating a problem in the distribution of health services."

Medicine since 30s

Doctor France observed that the 30s were the end of an era in medicine.

"In a deeper sense there has only been one era in medicine dating from the Golden Age of Greece, when Hippocrates separated medicine from philosophy . . . Yet, it may come somewhat as a shock to realize there have been more advances in the science of medicine in the past 40 years, than in the 40 centuries preceding," he said.

Doctor France talked about the scientific advances of the past 40 years.

"These years also have brought a new and multifaceted public social awareness and particularly, a new public sophistication and expectation in matters of health care. They have brought a vast array of new methods for the preservation of life and for the improvement of the quality of life, that did not exist at the end of World War II.

"It was in this period also that the medical profession, and not the government, established the high levels of professional excellence available to the American people today through the development of the American specialty boards which in recent years has included the American Board of Family Practice.

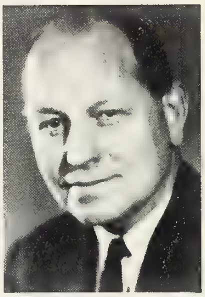
"It might also be pointed out," he said, "that a number of social problems have complicated and increased the burden of our health care system, such as poverty, educational deficiencies, social unrest with violence, drugs, environmental health problems, the stress and tensions of modern life, the changing social mores especially as they affect our young people, the trauma of our highways, for which society often turns to the medical profession for solutions."

Doctor France will serve through December, 1979.

Doctor Gagliardi sums up

Outgoing president Carl A. Gagliardi, MD, talked of the many WCMS activities of the past year and said there is much yet to be accomplished.

"Notable in this area," he said, "is the need to interest the large number of physicians both within and without our membership who are preoccupied with their own private affairs and too little involved with the broad activities which will help to preserve American medicine as a private system, still the envy of the rest of the world.


Doctor France

Doctor Gagliardi

"The present administration in Washington has retreated from a Kennedy type of government-controlled, all-inclusive medical care program for the present time," he said. "If we should all band together more effectively, and if we should make every effort to slow down the increasing cost of medicine, and if we should continue to earn the goodwill of our patients, we could probably postpone it for many years to come and thereby be able to continue to offer the very finest medical care available anywhere.

"We owe this to our patients now and to our children who follow us," he said.

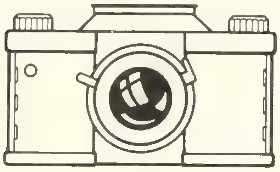
Enter MSMS photo contest with your INTRAV trip photos

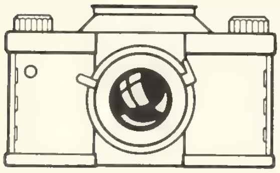
MSMS is sponsoring a photo contest!

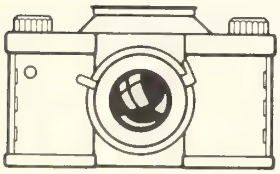
The contest is for all MSMS members and guests who have taken part in MSMS INTRAV trips from June, 1978 to May, 1979. MSMS trips during that time include the Rhine River Adventure, Eastern Mediterranean Air/Sea Cruise, the West Indies Air/Sea Cruise, African Adventure, Egypt/Greek Isles Adventure and Egypt Adventure.

Winners of the photo contest will see their photos published in the July issue of *Michigan Medicine*. First place winners will receive a prize of $50 free sight seeing on their next INTRAV adventure, and all contestants will receive INTRAV T-shirts.

Entries must be postmarked May 15, 1979, and received no later than May 20, 1979. This allows MSMS members planning trips in the next few months to take some good shots with the contest in mind.







If you'd like to enter the contest, you can obtain complete information from Marce Ireland at MSMS headquarters.

The rules are:

1) The contest is restricted to travelers confirmed through MSMS on INTRAV trips of June 1978, to May 1979.

2) There will be a limit of three entries per MSMS member.

3) Both black and white, and color photos are eligible and will be judged separately.

4) Categories will be broken down into "scenes," "people of the region," and "MSMS members and guests on the trip." There will be a total of six categories, with the three above subdivided into color and black and white.

5) Photos must have been taken by the entrant.

6) No contact prints are allowed.

7) Photos must be at least 5 × 7 inches and must be mounted.

8) Photos must have title on front in lower left-hand corner of matte board.

9) Back of matte must carry information as follows: Title, category, INTRAV trip on which photo was taken, date photo was taken, name and address of photographer.

10) Photos must be postmarked May 15, 1979 and received no later than May 20, 1979.

11) Judge will have the right to reclassify any photo or disqualify any entry. Photos will be judged on suitability for publication as well as quality and impact.

New supplement to pharmacopeia now available

A cumulative Fifth Supplement to USP XIX and NF XIV, the largest in compendial history, has been published by the US Pharmacopeial Convention, Inc.

Ten new monographs and six new reagent specifications are being introduced; three minor name changes are adopted; a section on interpretation of results is added to the dissolution test chapter and a dissolution test is added to the monograph on Nortriptyline Hydrochloride Capsules: Revisions also are made in four USP and NF chapters on container standards. Holders of the main volume of USP XIX and of NF XIV will need only one copy of the Fifth Supplement to bring both books up to date.

The Fifth Supplement is available at $5 per copy (cash with order), from the USP Convention, Inc., 12601 Twinbrook Parkway, Rockville, Maryland 20852.

Medical students may serve with National Guard

Michigan physicians should be alerted to a new program available to medical students through the Michigan National Guard.

Students who have successfully completed one year of medical school are eligible for the program, which consists of doing histories and physicals on National Guard personnel under supervision of a physician one weekend per month. Students sign up for a year's service and are paid approximately $100 per weekend.

Further information is available from Maj. Robert P. Lech, Michigan National Guard, 207th Combat Support Hospital, 4400 E. Eight Mile Road, Detroit, 48234.

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10850 Traverse Highway
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Deaths

Ethelene J. Crockett, MD
Detroit

Ethelene J. Crockett, MD, Detroit gynecologist-obstetrician, died Dec. 28 at the age of 64. A Howard University School of Medicine graduate, Doctor Crockett was the first woman to be president of the American Lung Association, the nation's largest and oldest voluntary health organization. She was director of clinics for Crittendon Hospital. Doctor Crockett played an important role in organizing Detroit's neighborhood health programs and was a member of the executive committee of the medical board of Harper Hospital. She also was on the executive board and was chairperson of the Health Committee of New Detroit, Inc. and was a member of the board of directors of the Health Care Institute of Wayne State University, United Community Service and the Michigan Cancer Foundation. In 1977 the Detroit Medical Society selected Doctor Crockett as "Physician of the Year." She was a member of the American College of Obstetricians and Gynecologists.

Frank E. Curtis, MD
Grosse Pointe Farms

Frank E. Curtis, MD, 86, of Grosse Pointe Farms, died Dec. 27. Doctor Curtis, who graduated from the University of Michigan Medical School, taught there and at Wayne State University School of Medicine. He was former chief of orthopedic surgery at Grace Hospital, Detroit, was a clinical assistant at Detroit Children's Hospital, and was staff consultant at Highland Park General Hospital. Doctor Curtis was a member of the Michigan Orthopedic Association and the American Academy of Orthopedic Surgeons.

Raymond G. Finnie, MD
Hastings

Raymond G. Finnie, MD, a Hastings area family physician, died Dec. 21 at 79 years of age. He graduated from the University of Michigan Medical School and was a flight surgeon in the Army Air Corps during World War II. Doctor Finnie was past president of Barry County Medical Society.

Robert H. Fraser, MD
Battle Creek

Robert H. Fraser, MD, Battle Creek, died at 87 on Jan. 14. He graduated from the University of Toronto medical school. While pursuing medical studies in Europe, Doctor Fraser presented a paper in German before the Austrian Otological Society. He was a student of Greek, Latin, German and French and also did several translating assignments for medical journals. His professional affiliations included the American College of Surgeons, the American Academy of Ophthalmology and Otolaryngology, and the Chicago Otological Society. He was past president of the Calhoun County Medical Society, and a member and past president of the Calhoun County Unit of the American Cancer Society, and was on the staffs of Leila, Community and Battle Creek Sanitarium hospitals.

Norman J. Goode, Jr., MD
Birmingham

Norman J. Goode, Jr., MD, Birmingham, died Jan. 4 at the age of 62. Doctor Goode obtained his degree from Jefferson Medical College of Thomas Jefferson University, Philadelphia. He was associate medical director for Detroit Edison Co.

Donald B. Morrison, MD
Battle Creek

Donald B. Morrison, MD, Battle Creek, died Dec. 31 at the age of 73. A graduate of Wayne State University School of Medicine, Doctor Morrison served as the team physician for Battle Creek Central High School athletes. Among his greatest accomplishments was his work in directing the Salk vaccine pilot study program in Calhoun County. He was a past president of Calhoun County Medical Society.

Randall O'Rourke, MD
Warren

Randall O'Rourke, MD, 79, Warren, died Jan. 27. A graduate of the University of Minnesota, Doctor O'Rourke was medical director at the U.S. Automotive Tank Command in Warren. He authored, "Thoughts of a Catholic Doctor," and was a member of the American Academy of General Physicians.

Orlando W. Pickard, MD
Detroit

Orlando W. Pickard, MD, Detroit, died Nov. 8 at the age of 86. He graduated from the University of Michigan Medical School. His professional memberships included American College of Surgeons, American Board of Obstetricians and Gynecologists, Central Association of Obstetricians and Gynecologists, Michigan Society of Obstetricians and Gynecologists of which he was past president, Detroit Academy of Surgery and Detroit Surgical Society.

Howard P. Staub, MD
Allen Park

Howard P. Staub, MD, 79, Allen Park, died Jan. 18. A retired director of the medical unit of the Ford Motor Co. Wixom plant, Doctor Staub was a graduate of the University of Oregon Medical School. He was a fellow of the Industrial Medical Association.

William Williams, MD
Flint

William Williams, MD, Flint, died Jan. 15 at the age of 90. Doctor Williams established the infirmary at the Fisher Body Flint Plant when it first opened. He was honored by the Genesee County Medical Society for 50 years of service to the area.

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Part-time staff may be answer to doctor's office help needs

By R. Timothy Hogan, CPBC
Ann Arbor

Increased productivity is the name of the game in the health care field these day. Thus, how a doctor staffs his office and utilizes his personnel is a key concern. Labor costs consume anywhere between 30 and 40 percent of overhead so the MD must be sure to employ the right number of assistants — and assure each one is busy the majority of the time.

Hospitals, particularly the for-profit hospitals that have taken a leaf from industry's book, have a way to maintain staff at full complement when necessary but at a reduced level when requirements for help diminish. The idea is to use certain employees on a part-time basis during peak periods but not to carry them on the permanent payroll in slack times. In some cases two persons share the same job, dividing responsibilities between themselves.

Every practitioner has a certain number of employees that he considers essential to running his practice — the "regulars" who are loyal, dedicated, competent, and worth every dollar he pays them. If he is productivity-conscious, as he should be today, and intends to increase his patient volume in the ensuing months, he may conclude that he needs additional help.

Does that new employee necessarily have to be a full-time person? Or would the answer be to find one (or even two) individuals who can work on an ad hoc basis as needed, knowing that's how the job is structured?

Maybe the doctor decides that to see more patients, one of the assistants will have to handle a heavier workload related to helping with patients. There will be an increasing amount of clinical and financial record-keeping to do as well. So perhaps bringing in a part-time employee to handle all insurance work, for example, is the solution.

The payroll increases, but not as much as if a full-time employee had been added who could not be kept busy every day. The cost of fringe benefits for such a part-time employee also is lower. As the new part-timer (or part-timers) work into the picture, the added patient volume may make it clear that the doctor does indeed require the addition of another permanent full-time assistant. And sometimes the problem solves itself because the experienced part-timer decides to work more hours.

The employee who doesn't work a full week must be brought into the office with serious attention given to delineating specific duties, where and when to work. His or her role and how he or she will relate to other employees must be carefully explained so there are no causes for potential friction with other workers. Regular employees sometimes tend to dump what clerical workers call "scut work" on part-timers, though the practitioner may not even know it. If that's part of the job and the new employee knows it, fine; if not, it can spell trouble. A doctor must make clear just what the newcomer is to do and emphasize that the job is important, since part-timers feel the need to be "needed."

Sometimes a practitioner wonders if the office is overstaffed during times when he or she must be away from the office for periods of several days or weeks. Should the office shut down completely and all employees take vacations at the same time? That's sometimes a hardship on workers who must adjust their vacation schedules to those of their spouses and children. With part-time employees there's no problem here; they know they'll be working as needed.

If a doctor decides to staff the office while he or she's away, the productivity question arises again. This period when no patients will be coming into the office theoretically is "down time." It need not be. It can provide a golden opportunity for accomplishing the tasks that regular employees normally don't have time to do within the working week.

It takes advance planning, but this is a good time to get painting, decorating, heavy cleaning, refurbishing or remodelling done. This is the time to arrange for equipment checks, for housecleaning and reorganizing of files, for catch-up with paperwork, miscellaneous correspondence and chores that just don't seem to get done in the normal working day. Employees can be given a chance to do some planning and perhaps revamping of office systems that will add to the efficiency of operation. When the doctor returns, everything will be in order.

Mr. Hogan is a management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

Classified

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

STAFF PHYSICIANS, East Lansing, Ingham County — Michigan State University student health service is currently recruiting for full-time staff physicians. The University has a student enrollment in excess of 40,000 and is located in a metropolitan area of 250,000. Athletic and cultural programs are available to staff. Olin Health Center is located on campus and provides facilities for students in need of medical, surgical or psychiatric care. Facilities include a large outpatient program, in addition to a separate outpatient gynecological clinic, limited inpatient capability and completely outfitted private office suites. Physicians must be licensed to practice in Michigan or immediately capable of obtaining such a license. Professional work is in the area of general practice with surgery confined to limits of the physician's experience. No pediatric, geriatric or obstetrical service. Physicians rotate night and weekend duty. Fringe benefits include TIAA CREF retirement program, paid hospital and malpractice insurance, one month paid vacation and liberal sick leave benefits. Starting salary negotiable. Contact: Michigan State University, Personnel Office, 110 Nisbet Building, East Lansing, MI 48824. EOE.

MICHIGAN, GRAND RAPIDS — full-time career oriented emergency physicians. Full specialty backup, 40,000 visits per year. Competitive compensation. Prefer two years post-grad experience EM or related field. Apply to Emergency Care Center, P.C., 200 Jefferson SE, Grand Rapids 49503.

WANTED: Board Cert. or Board Elig. internist, gen., or with subspecialty. Univ. comm. of 40,000 with drawing area of about 100,000. One hour from ocean, mountains or desert. Six months guar. income. J.A.C.H. approved hosp., lic. for 1975 beds. Resume: Box 1506, Loma Linda, CA 92354.

PSYCHIATRIST — Staff position at Lakewood Clinic, a psychoanalytically-oriented outpatient clinic in Birmingham, Michigan. Responsibilities include consultations and psychotherapy. Excellent opportunity for supervision and attendance at weekly seminars. Contact Medical Director, Lakewood Clinic, P.C., 280 North Woodward, Birmingham, Michigan 48011. Phone: 313/645-0022.

PSYCHIATRIST FOR ADULT foster care homes. We provide you with our patient list, you do your own billing. A ready made practice (of greater than 100 homes). Call 313/861-4400, Trail Clinic Secretary Cindy Papuga.

DUE TO RECENT retirement the position of medical director is open in Chase Center, a privately owned 233 bed extended care facility. Health care community is saturated with the philosophy of openness and cooperation. Logansport is a county seat town of 22,000 population in mid-north Indiana. Complete information will be forwarded upon request. Contact Rob James, Administrator, Chase Center, Logansport, IN 46947.

POSITIONS AVAILABLE — With offices in Lansing, Oak Park and Traverse City, there are openings for physicians board certified or qualified as internists, family physicians or psychiatrists working with the Disability Determination Service under the Social Security Administration. Salary currently between forty-seven and fifty-eight thousand per year, plus 23% fringe benefits, including life, accident, long term disability, dental, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years service. Liability insurance not necessary. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7830. In Michigan, call toll free 1-800-292-2710.

OCCUPATIONAL PHYSICIAN — For large multi-specialty group in beautiful Milwaukee, WI area — new facility of long established clinic. Office space and all equipment supplied by group. Pre-employment exams, diagnostic evaluations, on-the-job injuries for more than 300 Milwaukee area plants. Challenging position with great future for advancement. Excellent salary — many fine benefits including liberal profit sharing plan. Replies held in strictest confidence. Write Box 12, % MSMS.

Positions wanted

PHYSICIAN, BOARD CERTIFIED in general surgery, 52, excellent health, broad emergency, occupational and general medical experience seeks relocation; permanency and retirement benefits essential. Write: MSMS, Box 26, 120 W. Saginaw St., East Lansing 48823.

Miscellaneous

OFFICE SPACE — New medical center in prime location in Brighton, 8589-8599 W. Grand River. Will customize unit to your needs. Call — Davis Professional Bldg., 313/229-2752.

FOR SALE — Between Lansing and Flint, one hour north of Detroit. Office building and furniture and equipment (including X-ray). Eleven rooms inclusive. Practice possibilities have no limits (patients or monetary). Nice atmosphere. Please contact: Michigan State Medical Society, Box 2; 120 W. Saginaw Street, East Lansing, MI 48823.

MICHIGAN PHYSICIANS MUTUAL Liability Company surplus certificate for sale. Basic value $1,000. Please call 1/616/343-5376 on Mon., Thurs., Fri., 9:30 a.m. to 4:30 p.m.

OFFICE SPACE FOR LEASE between 14 and 15 Mile Road on Utica Road, Fraser. Summer of 1979. Next to golf course, airport. Across from hockey, racquet ball and tennis complex. Near St. Joseph West and South Macomb hospitals. 313/772-5070, 313/286-5757.

President's page

Planners fail to see MD need

Doctor Heideman

Planning seems to be an integral part of organizational, industrial and governmental functioning at all levels. Untold millions of dollars are spent on this process each year. A look at recent health manpower planning may be informative as to how effective the process is at the governmental level and how useful it is in the decision-making process.

There was concern for some time about physician fees, with the charge that these were maintained by physicians through their professional organizations by controlling the medical educative process. If more physicians were available there would be more competition among physicians with restoration of market mechanisms and control of fees.

This culminated in 1963 in federal legislation promoting the expansion of the medical schools and the creation of new ones. This was followed by legislation providing for expanded loan programs, scholarships, admission of students committed to service at governmental direction, the creation of the military service school and the provision of capitation funds to finance the expanded medical school programs.

As a result of these activities the capacity of our medical schools was expanded from an entering class of approximately 8,750 in 1967 to over 16,200 in 1978 and a further increase to 18,000 by 1980. This does not take into account admissions to the schools of osteopathic medicine which have expanded in a similar manner. This has resulted in an annual four percent increase of graduates from medical schools over the increase in population.

Concomitantly, Duke Medical School started its physician assistant program. The same period saw the emergence of the nurse practitioner and nurse clinician programs. These were justified on the basis of compensating for the vaunted health manpower shortage by increasing the number of patients the physician could provide care to through use of physician extenders. These could be trained at less expense and in a shorter period of time than could physicians.

Charles Edwards, MD, former assistant secretary for health and surgeon general, as one of his last acts in office, called attention some four years ago to the fact that we had over-extended our medical schools and were facing a situation which we had previously encountered in engineering and in education. Califano has taken up the same cudgel with the theme that there is no satisfying the demand for medical services and that every new physician means an expenditure of an additional $250,000 or $300,000 dollars a year.

No one has delineated what are *needed* health services which every person has a right to. Without this, we don't know how many physicians and other health workers we need.

And interestingly enough, the cry of an oversupply of physicians is being made before we have had any real impact on health care delivery from the expansion of our medical schools and at the same time that people are still complaining about how long it takes to get an appointment with a physician.

It takes about 10 years to graduate the first class after a decision is made to develop a new medical school and another three to five years before they enter medical practice. Industry is familiar with "lead time," but the planners and the legislators think all that needs to be done is to open the spigot and professionals are available, and are disappointed by the fact that there isn't an immediate return on the investment. The most significant reality is that the 25 percent of our population who were reported as unserved or underserved according to the 1960's figures has been reduced to 10.2 percent according to data from the 1973-74 National Health Survey and to some 12 percent according to a more recent survey.

I find this was accomplished primarily in the private sector through physicians accepting responsibility for an increased number of patients. Let me hasten to add that I believe some expansion of our schools was indicated, but that new ones were developed disproportionate to the need and without taking into account graduates of foreign medical schools, most of whom are just completing post-graduate education and entering practice.

So the planners failed to take many developments into consideration, failed to consider lead time, failed to establish requisite criteria for estimating health needs, and the administrators then failed to consider the impact of new factors and to modify programs appropriately.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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ROCHE

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The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introita colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

Michigan Medicine
Medigram
BREAKING NEWS FOR MICHIGAN DOCTORS
VOL. 78, NO. 9
MARCH 27, 1979

Physicians', Blues' proposed new system goes to Michigan doctors for consideration

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APR 12 1979

By Millicent Lane
Special to Michigan Medicine

A new system for Blue Cross-Blue Shield cost containment to Michigan physicians will be considered when the Michigan State Medical Society (MSMS) House of Delegates meets in May.

The cost containment proposal comes as a package tying together:

— A cost containment program providing for physician monitoring of health care expenditures and for sanctions against abusers.

— An "effective service benefit" program based on 80 percent physician participation in the Blues.

— Formulas for reimbursement which would include automatic annual adjustments in the maximum payments.

— Equal treatment of all physicians within a reimbursement system consistent with the above three factors.

Before the system can take effect in July, it must be approved without change by both physicians and Blues, whose representatives worked out the proposal as the "Physician Liaison Committee."

"We've been working at this more than six months," said Donald K. Crandall, MD, of Muskegon. He would rather see a system worked out "by physicians sensitive to quality medical care than bureaucrats sensitive to dollars."

Crandall headed the MSMS physician work team on the committee which also included John B. Bryan, MD, Royal Oak and Frank B. Walker, MD, Grosse Pointe Park.

Your chance to advise

Every active member of MSMS will receive a text of the proposal between Michigan physicians and BCBSM, with a postcard mail ballot to express individual member's preference. Watch your mail! Submit your opinion! The collective advice of the membership will go to the House of Delegates May 4, which will take action on the proposed plan.

Edward A. Loniewski, DO, Farmington Hills represented the Michigan Association of Osteopathic Physicians and Surgeons whose House of Delegates also meets in May to consider the proposal.

An initial review of the proposed system came March 8 from the Blue Cross-Blue Shield (BCBS) board. Its representatives on the physician Liaison Committee were Frank Blackford, president, Macomb County Community College; Walter Maher, vice president, Chrysler Corporation; Ellsworth G. Reynolds, president, American Natural Service Company; and Robert Walker, coordinator, benefit plans section, United Auto Workers.

The proposed system ends months of differences between the Blues and Michigan physicians.

Primarily through MSMS efforts, deliberations finally led to a proposed agreement in principle between MSMS and BCBSM which was adopted by the House of Delegates and the Blues board last year.

MSMS delegates' goals

The reimbursement proposal spells out the agreement in principle and meets these goals assigned by the House of Delegates to the MSMS work group in 1978:

1. Establish a statewide screen for all physicians, while eliminating the

(Continued next page)

A typical session of the Blues' and physicians' work groups at MSMS headquarters had Donald K. Crandall, MD, physician work group chairman at the head of the table. Down the right side of the table, from his left, are physician work group members Frank B. Walker, MD; John B. Bryan, MD; Edward Loniewski, DO, and William Madigan of the MSMS staff.

generalist and specialist differentials in payment.

2. Establish a fair and equitable cost containment program that would help contain the rising costs of medical care.

3. Streamline the present usual, customary and reasonable (UCR) reimbursement system.

4. Provide equity in payment to participating and non-participating physicians alike.

Since that House of Delegates meeting, the work groups have spent more than 400 hours to complete the task assigned to them. The result is the proposed reimbursement system.

Cost containment program

To achieve the cost containment objective under the new system, the committee recommended establishment of state and regional committees that would monitor not only physicians but subscriber groups also.

A 10-member state committee would provide the overall direction to the containment program. It would:

— Consist of three MDs, one DO, and six consumer members.

— Establish an annual state per-member expenditure goal for services rendered or ordered by physicians. Factors considered would be per-member expenditures for the state as a whole, figures for benefit categories, inflation, service intensity, productivity, benefit changes and utilization trends.

Physicians would comprise two-thirds of the regional committee membership. Region boundaries would be based upon the 15 Councilor Districts of MSMS with possible modifications to accommodate differences between MSMS and MAOPS districts. The regional committee would:

— Investigate if its per-member expenditures exceed the average of per-member expenditures for all regions and report to the state committee within a reasonable period of time with a plan to solve or reduce the problem or problems.

— Be empowered to recommend sanctions by BCBSM against physicians, against health care providers providing services ordered by physicians, or against subscriber groups. Sanctions against providers could be reduced payments. Against subscribers, they could be co-pays or deductibles on a benefit or modification of a specific benefit.

The cost containment program also provides an appeals procedure.

Reimbursement programs

The "effective service benefit" program leans heavily on the Blues' 40-year history in health care related to the service benefit concept. Elements in an effective program would provide that:

— Physicians and other professional providers of health care agree to look solely to BCBSM for payment of certificate-covered services, less any applicable co-payments or deductibles.

— Formal participation by 80 percent of the physicians in a region and in a specialty also. Payment directly to participating physicians and to the subscriber if his physician is non-participating.

Under the new reimbursement program, BCBSM calculates the changes would mean a 12.7 percent increase in the 1979 Blues payout to physicians over the 1978 payout of $468 million.

Major provisions of the reimbursement program (which hinges upon implementation of the cost containment and effective service benefit programs) include:

— Establishment of fees at that level which will pay 85 percent of the aggregate charges in the 12-month period ending Dec. 31, 1978.

— Adjustment of each physician's profile on July 1 to his current charge patterns, measured by the most frequently billed charge for a procedure during the period from Jan. 1, 1978, to Dec. 31, 1978.

— Adjustment of each physician's profile annually based on a Profile Limitation Factor index with 40 percent based on the cost of doing business and 60 percent based on the increase in general earnings of similar professionals.

The cost of doing business includes salaries, rent, car, drugs, miscellaneous and professional liability insurance. The earnings component derives from salaries listed in the American Management Association's "Professional and Scientific Positions Report."

— A recommendation for a modified UCR reimbursement system for lab and pathology services, low frequency services, services performed by a limited number of physicians, new technology and new medical techniques, services performed at alternative locations and some other procedures.

Appropriate maximum screens would be set by BCBSM to provide incentives for physicians to provide services at the least costly location, in physician offices instead of a hospital when possible, for example.

Payments to participating and non-participating physicians would be the same under the proposed reimbursement system but might differ under provisions of employee benefit programs administered by BCBSM.

by the work group that "a minority of physicians on these committees is better than none at all," is specious. There are no pictures on a scorecard — losing a vote in committee six to four is as bad as 10 to 0.

Physicians will be "sanctioned"

Although accustomed to self discipline in a well-disciplined profession, physicians will never accept loss of ability to earn a living on the basis of alleged transgressions determined by ill-defined consumer-oriented entities dubbed regional committees. The posture of the non-participating physician vs. the participating physician has become much clearer in light of the recent U.S. Supreme Court decision anent the Royal Drug Case, which urges that such disputes should be decided by courts of law and not by sanctions which result in non-payment or outright suspension of the non-participant. "Sanctions" are approbations which may function in the field of international diplomacy but not in areas of intra-professional discipline.

"Per-case participation"

The loss of per-case participation must only harm the patient most, since he will be unable to obtain care from the physician of his choice if that physician opts not to participate in an untenable pre-negotiated contract. Per-case participation was an arrangement born by a consent judgment in the circuit court, which has worked well and has benefited the consumer. It is a crucial point to most physicians, any statistical resume from Blue Cross/Blue Shield to the contrary.

Prior negotiated contracts

Prior contracts dictating *payment for care to participating physicians only* are not to be altered by anything in the present proposal. The UAW and the organizations controlled by them through the bargaining process have negotiated away many physicians' rights to determine fees and other obligations in the delivery of health care. It can be anticipated that many other such contracts will be negotiated in the future. If this is considered equality of treatment my definitions differ from those of the work group.

Fee for service concepts

The proposal alters the fee-for-service mechanism by abandoning the concept of usual, customary, and reasonable reimbursement. It is a short step to capitation payment schedules from the complex formulae for payment for care under the proposal.

Participating agreement

The proposal fails to define the real relationship between the participating physician and BCBSM. The promises of "automatic profile updates," "$60 million in total new money for reimbursement," and "equality of treatment" are false and fragile inducements to ratify the proposal. Somewhere, somehow the participating contract should have been studied and discussed. Certainly, the old covenant fails to protect the participating physician. The new program is said to allow a 60-day opt-out clause which is little comfort since it gives Blue Cross/Blue Shield 45 more days of physician servitude than the previous participating agreement. This is no substitute for the definition of a better adversary role of the participating physician group vs. BCBSM. BCBSM is an insurance business and it must function in the market place with physicians, not under the guise of a protector with special privileges.

What action is necessary?

1. Thank the negotiating committee and dismiss it at once.
2. Urge the MSMS Council to strongly disapprove the proposal if it cannot totally reject it.
3. Demand the House of Delegates meet without further delay in special session to consider the proposal.
4. If renegotiation is still viable, establish a new committee of physicians which will meet with representatives with BCBSM in the open, with continuing advice from both the profession and others experienced in negotiation and in the legal nuances of third-party problems.

This so-called proposal is not a proposal, but a sell-out. It surrenders everything for which many of us have fought over the last 25 years. It is potentially catastrophic to the delivery of health care to the citizens of Michigan. A word to the wise is sufficient.

BED REDUCTION FORMULA STUMBLES OVER OCCUPANCY RATE REQUIREMENT

The formula for effecting hospital bed reduction in Michigan ran into political turmoil as it moved from the State Wide Health Coordinating Council. Interested parties now are seeking compromise criteria. The legislative leadership raised serious questions about the 91 percent occupancy rate requirement for hospitals, and the matter has yet to be taken up formally by the Joint Administrative Committee. Meanwhile SHCC turned over to its executive committee authority to negotiate a reasonable occupancy rate, while some opponents of the 91 percent figure are arguing for removal of any occupancy rate criterion and are seeking a flat 3,800 reduction in hospital beds. Responsibility for identifying the 3,800 beds would fall to regional HSAs. A technical deadline for final decision is April 5, though it probably will take longer to work out precise final language. MSMS is opposed totally to the 91 percent occupancy rate as too rigid and too high, and a barrier to hospital services for patients.

Rep. Kehres cites urgency of Medicaid cost consciousness

Rep. Raymond Kehres of Monroe, chairman of the Sub committee on Social Services of the House Appropriations Committee, has urged doctors and hospital to be especially sensitive to the voluntary effort to reduce Medicaid costs. The voluntary program was urged by Rep. Kehres in lieu of mandated cost ceilings and prior authorization for elective surgery. The Governor, Speaker of the House and Majority Leader of the Senate informed Medicaid providers of the program, asking their cooperation Rep. Kehres told MSMS, "This is your opportunity to prove the voluntary effort. We are asking doctors and hospitals to find their own ways to reduce Medicaid costs in this tough fiscal year. If this works, we will know the voluntary approach is good; if it doesn't, we will have to apply cost ceilings. I trust doctors and hospitals. I hope they can deliver on this voluntary program."

MSMS watching legislative activity on bill to restructure Blues board

H B 4340, a proposal to restructure the board of directors of Blue Cross/Blue Shield of Michigan, was subject to its first hearing before the House Insurance Committee March 22. A subcommittee of the MSMS Committee on State Legislation and Regulations has been appointed to monitor and evaluate the legislation. The bill, proposed by Reps. David Hollister of Lansing and Bill Ryan of Detroit, would reduce the size of the BCBSM board from 47 to 28. The new board would consist of its president, 20 subscriber members and seven provide members. Two provider members would be doctors of medicine and one would be a doctor of osteopathic medicine. The bill also would establish six customer advisory councils whose purpose is to establish a communication link between BCBSM and its 5,000,000 subscribers.

Michigan State Medical Society
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Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine
Medigram

VOL. 78, NO. 10 APRIL 9, 1979

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ıPSULES

ıE USUAL LARGE CROWD of team
ıysicians, coaches and
ːhletic trainers is expected
ɔr the 1979 MSMS Conference
ı the Medical Aspects of
rganized Athletics, April 12
t Towsley Center, University
f Michigan Medical Center,
ın Arbor. The Michigan
thletic Trainer's Society is
ɔ-sponsoring this year's
vent, which drew more than
)0 people in 1978. Hand,
ye, shoulder and knee injur-
es will be discussed at the
ll-day meeting, as well as
ıtrition for athletes,
omen's athletics and taping.
ıformation is available from
ert Scholten at MSMS
eadquarters.

* * *

IFTY-FIVE CATEGORY I COURSES
re being planned for the
979 MSMS Annual Scientific
eeting by the ASM planning
ommittee. The MSMS meeting,
ne of the largest state
ociety-sponsored Category I
eetings in the country, is
lanned for Nov. 13-14-15 at
ne Hyatt Regency Dearborn.
hairman is Samuel M. McMahon,
D, Lansing. Information is
vailable from Sherry Fent
t MSMS headquarters.

* * *

AYNE COUNTY MEDICAL SOCIETY
embers have voted to approve
ew county society bylaws.
abulations were just com-
leted April 3, with the
nnouncement being made to
he WCMS councilors as this
edigram went to press.
urther details will follow
n future issues.

Bed reduction criteria withdrawn for compromise

Criteria and guidelines to effect a hospital bed reduction plan in Michigan were withdrawn by the Statewide Health Coordinating Council when it became apparent the 91 percent occupancy rate criterion would not receive legislative approval. Compromise criteria have been developed in consultation with the Michigan Hospital Association, and will be resubmitted to the Legislative Joint Rules Committee for action this month. Jay G. Endsley, secretary to SHCC, said the major revisions to the guidelines and criteria would 1) Establish a statewide minimum bed reduction target of 3,800 beds and regional targets for each of the state's health service areas; and 2) Provide that, in publishing the list of subareas which have 25 or more excess beds, the Department of Public Health may use any methodology which is consistent with the minimum state and regional bed reduction targets. Mr. Endsley said that in view of the compromise arrangement on hospital bed reduction, the SHCC will consider amendments to the proposed State Health Plan to make it consistent with criteria and guidelines. The State Health Plan will be formally transmitted to the Legislature shortly. Legislative approbation is required to implement the plan.

Check your mail for ballot on MD/Blues proposal

It is extremely important that every MSMS member read the information on the physician and Blue Cross/Blue Shield of Michigan proposals described in the March 27 Medigram and the April Michigan Medicine. In a separate mailing you will receive an advisory ballot on those proposals to be completed and returned to MSMS headquarters by April 28. The March 27 Medigram and April Michigan Medicine, as well as the special ballot mailing contain detailed information about the proposals. Please contact MSMS headquarters if you do not receive these special issues and the ballot mailing.

CAPSULES/Cont.

THE MICHIGAN OPHTHALMOLOGICAL SOCIETY has two executive committee meetings scheduled in coming weeks. The meetings, open to all MOS members, will be held April 16 and May 21 at the Wayne County Medical Society headquarters. Interested physicians may contact Susan Grimsley at MSMS headquarters. 517/337-1351.

* * *

AMA AND MSMS CONCERNS will be shared at a discussion/reception planned for May 4 at the Kalamazoo Hilton Inn just prior to the 1979 MSMS House of Delegates meeting. All MSMS and AMA delegates and alternates; members of AMA boards, councils and commissions; presidents of specialty and county medical societies; MSMS councilors and executive secretaries of component societies are invited. Featured guest at the 3:45 p.m. event will be a representative of the AMA Board of Trustees, who also will be attending the House of Delegates meeting.

* * *

MSMS MEMBERS ARE URGED to encourage their medical assistants to attend the 29th Annual Convention of the Michigan Chapter, American Association of Medical Assistants, April 26-29 at the Hilton Inn, Lansing. Of particular interest to the physician and his/her office staff are: 1) an all-day workshop Friday, April 27, presented by Practice Productivity of Atlanta, and 2) a panel discussion Saturday April 28 on "Challenges in Health Care," moderated by MSMS President Louis Heideman, MD. On the panel will be MSMS Council Chairman Louis R. Zako, MD, and Councilor Robert J. Toteff, MD. For more information contact Dolores Bliesener, 241 E. Saginaw, Suite 101, East Lansing, 48823. 517/351-8893.

MSMS delegates should plan now for 1979 House meeting May 4-6

It's time now for MSMS delegates and alternates to make housing reservations and buy tickets to the MDPAC luncheon and installation dinner planned duri the 1979 House of Delegates meeting in Kalamazoo Ma 4-6. Forms for housing and the luncheon and installation dinner were included in recent mailing to the delegates. Both events are scheduled on Saturday, May 5. Pre-registration also is necessar for the Upjohn pharmaceutical company tour planned for 1 p.m. Friday, May 4, by the auxiliary. Articles on the Upjohn tour and MDPAC luncheon are printed elsewhere in this issue.

* * *

MSMS delegates' spouses will hold their annual convention at the Kalamazoo Sheraton Inn at the time o the MSMS House of Delegates meeting May 4-6 at the Kalamazoo Center Inn. All delegates' spouses are invited to attend the annual meeting of the MSMS Auxiliary at the Sheraton. Buses will run between the Sheraton and Kalamazoo Center every 30 minutes. A special tour of the Upjohn pharmaceutical company has been arranged for 1 p.m. Friday, May 4. Pre-registration is required for the tour with Mr. Gerald Rigterink, convention chairman, 210 Grand View, Kalamazoo, MI 49001. There is no charge for the tour, which is open to MSMS delegates and alternates also.

* * *

Congressman Howard Wolpe (D-3d District), and State Senator John Welborn (R-Kalamazoo), will provide two views of the importance of political involvement as speakers at the 1979 MDPAC Annual Luncheon May 5. The event is scheduled for the Kalamazoo Center Inn, during the 1979 MSMS House of Delegates Annual Meeti The reception will begin at 11:45 a.m., with luncheo at 12:30 p.m. All MSMS members and spouses may atte Tickets are $8 each, with MDPAC sustaining members admitted free. Further information is available fro Gary Anderson at MSMS headquarters.

MSMS group health premiums adjus

Premium rates for MSMS members with group health insurance coverage will be revised as of May 1 to reflect the past years' claims experience. Rates wil go down in several instances, but overall rates will increase an average of 3.12 percent. Further information available from Wayne Burmeister at MSMS.

MSMS committees entertain legislators

even Michigan legislators and staff were guests of he MSMS Medicaid Liaison Committee April 3 for the nnual discussion of physicians' services in the edicaid program. David Siegel, MD, chairman, welomed the House and Senate Subcommittees on Social ervices Appropriations and reminded them that MSMS ad delivered a high level of physician participation n the Medicaid program as its part of a bargain hich includes bringing Medicaid reimbursements to arity with Medicare screens. Before full parity as realized, Doctor Siegel said, the cost contain-ent program for this fiscal year was implemented, alling short on the state's side. Rep. Ray Kehres, hairman of the House subcommittee, promised action o achieve the parity promise. Other legislators resent, along with nine physicians, were Sens. teven Monsma, Grand Rapids; Edward Pierce, Ann Arbor; nd Alvin DeGrow, Pigeon. Reps. present were David ollister, Lansing; Thomas Mathieu, Grand Rapids; and alph Ostling, Roscommon.

n April 10 several members of the MSMS Committee on tate Legislation entertained the House of Represen-atives Public Health Committee, which deals with all ajor items of health legislation. W.E. Maldonado, D, chairman, spoke for the medical society, offering dvice and information when available on all health egislation whether or not MSMS had a "stake" in it. ep. Raymond Hood, veteran chairman of the legislative ody, responded. Members of the House committee are eps. Hood, Detroit; Barbara Rose Collins, Detroit; eorge Cushingberry, Detroit; David Evans, Mt. lemens; Lucille McCollough, Dearborn; Stanley Stop-ynski, Detroit; Claude Trim, Davisburg; Bela Kennedy, angor; Mary Keith Ballentine, Jackson; Connie Bins-ield, Traverse City; Wilbur Brotherton, Farmington.

All MDs on SHCC reappointed

overnor Milliken has announced new appointments to he 54-member Statewide Health Coordinating Council. he new appointments are pursuant to Public Act 323 of 978, whereas the previous SHCC was constituted by irtue of an Executive Order. The SHCC is responsible or developing an annual State Health Plan, approving r disapproving applications for federal health funds nd advising the Governor, the Legislature and the ffice of Health and Medical Affairs on health planning and resource development. All physician members f the SHCC were reappointed. Appointed as providers t large were Maurice S. Reizen, MD, director of the ichigan Department of Public Health and Andrew D. unt, MD, Michigan State University. Appointed from SAS were D. Bonta Hiscoe, MD, Lansing; Richard J. otter, MD, Ishpeming; Robert J. Toteff, MD, Saginaw nd Ian D. Wilson, MD, Petoskey.

MSMS MEMBERS CONTINUE to express confusion over the medical ethics portion of requirements for Category I CME courses needed for Michigan relicensure. To clarify what is meant by medical ethics in those requirements, the Board of Medicine has stated, "The board believes medical ethics is an educational activity which allows physicians to upgrade their skills in dealing with issues of life and death." Earlier, *Medigram* pointed out the board believes any discussion of ethics at almost any conference dealing with patient management will meet the requirements.

* * *

THE OLDEST-KNOWN WILL was made by an Egyptian named Uah, 4,500 years ago! The MSMS Physician Service Group, Inc. urges physicians to follow the ancient example of Uah, whose historic will written on papyrus now resides in the museum at the University of London. By means of a carefully drawn will you can state clearly and definitely how you want your property distributed. Furthermore, you can name the Physician Service Group, Inc. to select the administrator who will handle the settlement of your estate, and your trustee, should you set up trust funds. For further information, contact: Robert T. Stanziano, Director of Financial Services, MSMS/Physician Service Group, Inc., P. O. Box 950, East Lansing, 48823, 517/337-1351.

* * *

CAPSULES/Cont.

MSMS ATTORNEYS and others interested in the countersuit by Seymour Freidman, MD, have met to coordinate their amicus curiae briefs in support of Doctor Freidman. There is a possibility the Michigan Association of Osteopathic Physicians and Surgeons, and the Michigan Hospital Association will be asked to file additional support briefs. Editor's apology: Doctor Friedman's name was incorrectly given in the Feb. 26 issue of Medigram.

MICHIGAN PHYSICIANS should be sending their forms for payment of treatments to CHAMPUS/CHAMPVA beneficiaries to Blue Shield of California, CHAMPUS/CHAMPVA Program, PO Box 85116 San Diego, CA 92138. Blue Shield of California replaced Blue Shield of Michigan as the fiscal intermediary effective March 1.

CORRECTION--Health Central of Lansing is not an IPA type HMO, as printed in the Feb. 26 issue of Medigram. Health Central, which is one of six HMOs around the country being visited by an AMA study group, is a staff model HMO.

MD health planning groups form

In response to a need for more physician involvement in local health planning, the Physician/HSA Support Center has facilitated organizational activities in two areas of the state. In Northern Michigan, Klaus Hergt, MD, East Jordan, chaired a meeting in Gaylord of leaders of component medical societies in the Northern Michigan HSA on March 22. The discussion resulted in the creation of a communications network utilizing chiefs-of-staff as a link between the HSA and physicians. A multi-county "executive committee" was established to mobilize physicians on relevant issues and provide physician consultants to the HSA. Theodore Vander Veen, MD, Grand Haven, has invited representatives of component medical societies in the West Michigan Health Systems Agency to meet on April 11 in Grand Rapids. Discussion will focus on the formation of physician task forces to parallel the HSA committees and the development of a communications network to keep physicians informed of activities in health planning. These two organization join the already operational Seven-County Physicians Advisory Committee, which is a multi-medical society committee on health planning in the greater Detroit area.

Bill to restructure BCBSM board expected to be first of several

More bills are expected in the legislature to restructure the Board of Directors of Blue Cross/ Blue Shield of Michigan. Rep. Matthew McNeely, Detroit, chairman of the House Insurance Committee, has called no further hearings on HB4340, which would change the board to 28 members dominated by subscribers, pending introduction of new legislation on the subject. Some testifiers asked for 60 to 90 days after the March 22 hearing to prepare their own ideas for submission.

Michigan State Medical Society
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Editor: Judith Marr

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CAPSULES/

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Contents

April 1979

Michigan Medicine

Special Section

169 **The details of the Michigan physicians/Blue Cross-Blue Shield of Michigan proposals for cost containment, as well as contrasting views, are presented in this month's special section;** Millicent Lane; Donald K. Crandall, MD and Donald N. Sweeny Jr., MD

Features

174 **The state's proposed formulas for reducing hospital beds in Michigan;** Dennis Paradis

182 **Report on the 1979 incidence of Reye Syndrome in Michigan;** Norman S. Hayner, MD

184 **Physicians' help needed in big push to immunize all state children;** Maurice S. Reizen, MD

191 **BCBSM Medical Necessity Program evaluating medical procedures;** Robert D. Young

194 **Donated eyes used for transplantation or research;** Betty L. Herring, and John W. Cowden, MD

201 **Corrected Maternal Health Desk Reference Card No. 23**

Departments

179 **Medico-legal;** A. Stewart Kerr

186 **MSMS/A;** Anita Yannitelli

190 **Meetings**

205 **Views;** James D. Fryfogle, MD; Louis E. Heideman, MD; John R. Ylvisaker, MD, and Archie Bedell, MD

215 **Business;** R. Timothy Hogan

218 **Letters**

220 **Category I courses**

224 **Welcome**

226 **Deaths**

228 **Classified ads**

229 **Ad index**

230 **President's page**

PHOTO BY MERT SCHOLTEN

An MSMS poll now being taken will reveal Michigan physicians' views on the Blues'/physicians' proposals for a new cost containment system. Special articles in this issue explain the system, worked out in negotiating sessions like the one pictured on the cover, with Donald K. Crandall, MD, at the head of the table. See pages 169-173.

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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Physicians', Blues' proposed new system goes to Michigan doctors for consideration

By Millicent Lane
Special to **Michigan Medicine**

A new system for Blue Cross-Blue Shield cost containment to Michigan physicians will be considered when the Michigan State Medical Society (MSMS) House of Delegates meets in May.

The cost containment proposal comes as a package tying together:

— A cost containment program providing for physician monitoring of health care expenditures and for sanctions against abusers.

— An "effective service benefit" program based on 80 percent physician participation in the Blues.

— Formulas for reimbursement which would include automatic annual adjustments in the maximum payments.

— Equal treatment of all physicians within a reimbursement system consistent with the above three factors.

Before the system can take effect in July, it must be approved without change by both physicians and Blues, whose representatives worked out the proposal as the "Physician Liaison Committee."

"We've been working at this more than six months," said Donald K. Crandall, MD, of Muskegon. He would rather see a system worked out "by physicians sensitive to quality medical care than bureaucrats sensitive to dollars."

Crandall headed the MSMS physician work team on the committee which also included John B. Bryan, MD, Royal Oak and Frank B. Walker, MD, Grosse Pointe Park.

Please see Views, page 205 for additional Blues articles.

Your chance to advise

Every active member of MSMS will receive a text of the proposal between Michigan physicians and BCBSM, with a postcard mail ballot to express individual member's preference. Watch your mail! Submit your opinion! The collective advice of the membership will go to the House of Delegates May 4, which will take action on the proposed plan.

Edward A. Loniewski, DO, Farmington Hills represented the Michigan Association of Osteopathic Physicians and Surgeons whose House of Delegates also meets in May to consider the proposal.

An initial review of the proposed system came March 8 from the Blue Cross-Blue Shield (BCBS) board. Its representatives on the physician Liaison Committee were Frank Blackford, president, Macomb County Community College; Walter Maher, vice president, Chrysler Corporation; Ellsworth G. Reynolds, president, American Natural Service Company; and Robert Walker, coordinator, benefit plans section, United Auto Workers.

The proposed system ends months of differences between the Blues and Michigan physicians.

Primarily through MSMS efforts, deliberations finally led to a proposed agreement in principle between MSMS and BCBSM which was adopted by the House of Delegates and the Blues board last year.

MSMS delegates' goals

The reimbursement proposal spells out the agreement in principle and meets these goals assigned by the House of Delegates to the MSMS work group in 1978:

1. Establish a statewide screen for all physicians, while eliminating the

A typical session of the Blues' and physicians' work groups at MSMS headquarters had Donald K. Crandall, MD, physician work group chairman at the head of the table. Down the right side of the table, from his left, are physician work group members Frank B. Walker, MD; John B. Bryan, MD; Edward Loniewski, DO, and William Madigan of the MSMS staff.

generalist and specialist differentials in payment.

2. Establish a fair and equitable cost containment program that would help contain the rising costs of medical care.

3. Streamline the present usual, customary and reasonable (UCR) reimbursement system.

4. Provide equity in payment to participating and non-participating physicians alike.

Since that House of Delegates meeting, the work groups have spent more than 400 hours to complete the task assigned to them. The result is the proposed reimbursement system.

Cost containment program

To achieve the cost containment objective under the new system, the committee recommended establishment of state and regional committees that would monitor not only physicians but subscriber groups also.

A 10-member state committee would provide the overall direction to the containment program. It would:

— Consist of three MDs, one DO, and six consumer members.

— Establish an annual state per-member expenditure goal for services rendered or ordered by physicians. Factors considered would be per-member expenditures for the state as a whole, figures for benefit categories, inflation, service intensity, productivity, benefit changes and utilization trends.

Physicians would comprise two-thirds of the regional committee membership. Region boundaries would be based upon the 15 Councilor Districts of MSMS with possible modifications to accommodate differences between MSMS and MAOPS districts. The regional committee would:

— Investigate if its per-member expenditures exceed the average of per-member expenditures for all regions and report to the state committee within a reasonable period of time with a plan to solve or reduce the problem or problems.

— Be empowered to recommend sanctions by BCBSM against physicians, against health care providers providing services ordered by physicians, or against subscriber groups. Sanctions against providers could be reduced payments. Against subscribers, they could be co-pays or deductibles on a benefit or modification of a specific benefit.

The cost containment program also provides an appeals procedure.

Reimbursement programs

The "effective service benefit" program leans heavily on the Blues' 40-year history in health care related to the service benefit concept. Elements in an effective program would provide that:

— Physicians and other professional providers of health care agree to look solely to BCBSM for payment of certificate-covered services, less any applicable co-payments or deductibles.

— Formal participation by 80 percent of the physicians in a region and in a specialty also. Payment directly to participating physicians and to the subscriber if his physician is non-participating.

Under the new reimbursement program, BCBSM calculates the changes would mean a 12.7 percent increase in the 1979 Blues payout to physicians over the 1978 payout of $468 million.

Major provisions of the reimbursement program (which hinges upon implementation of the cost containment and effective service benefit programs) include:

— Establishment of fees at that level which will pay 85 percent of the aggregate charges in the 12-month period ending Dec. 31, 1978.

— Adjustment of each physician's profile on July 1 to his current charge patterns, measured by the most frequently billed charge for a procedure during the period from Jan. 1, 1978, to Dec. 31, 1978.

— Adjustment of each physician's profile annually based on a Profile Limitation Factor index with 40 percent based on the cost of doing business and 60 percent based on the increase in general earnings of similar professionals.

The cost of doing business includes salaries, rent, car, drugs, miscellaneous and professional liability insurance. The earnings component derives from salaries listed in the American Management Association's "Professional and Scientific Positions Report."

— A recommendation for a modified UCR reimbursement system for lab and pathology services, low frequency services, services performed by a limited number of physicians, new technology and new medical techniques, services performed at alternative locations and some other procedures.

Appropriate maximum screens would be set by BCBSM to provide incentives for physicians to provide services at the least costly location, in physician offices instead of a hospital when possible, for example.

Payments to participating and non-participating physicians would be the same under the proposed reimbursement system but might differ under provisions of employee benefit programs administered by BCBSM.

Two views of the Blues/MD proposals

A word to the wise (to reject)

By Donald N. Sweeny Jr., MD
Detroit

Any attempt to assess the proposal reached by the work group of the combined negotiating committees from MSMS and Blue Cross/Blue Shield of Michigan must be impersonal and unemotional.

Those of us who totally reject the instrument resulting from these deliberations have the greatest respect for the energy, the sincerity and the forthrightness of the physicians and laymen involved. The bottom line of our analysis is simply that the proposal is not in the best interests of either patients or physicians, and must be rejected.

Since most of the deliberations were carried on in secrecy (a vacuum about which we worried enough to request a belated liaison committee), the resulting settlement is not too surprising. It is incomprehensible how any committee would consider negotiating such sensitive problems without immediate and continuing input from the leadership of the profession and the Blue Shield corporation.

There are many glaring reasons why the proposal must be turned down, such as the following:

Per member expenditure goal

The settlement sets up complex, devious, numerical factors to determine and restrict payment for necessary medical care. The concept of limitation of expenditures on basis of *cost effective rationing of care* may be an acceptable theory in economics, but to deny health care on the basis of an aggregate dollar amount per region (the dollar limit determined by a 60 percent lay committee) is not the way the American public wants or expects its health care delivered.

Consumer dominated committees

Peer review means a *review by peers*. The 15 regional committees established by the proposal to oversee and make policy concerning the propriety of care and the reimbursement for it, are laden with 60 percent consumers. Those regional groups are supported by a paternal state committee "to provide overall direction to cost containment as well as to establish an annual state per-member expenditure goal for services rendered and ordered by physicians." The argument advanced now

(Continued on page 173)

Doctor Sweeny is on the board of the National Association of Blue Shield Plans.

A time for decision (to support)

By Donald K. Crandall, MD
Muskegon

The new proposal of the Michigan physicians work group (negotiating team) and Blue Cross/Blue Shield of Michigan, completed in January, culminates an agenda dating back to 1974. It finally resolves many of the problems physicians of Michigan have had with the BCBSM's "service benefit program" for the past 10 to 15 years.

The details of the proposal and problems some physicians have with the program are described elsewhere in this issue. I would like to explain to the physicians of Michigan the advantages this proposal will have for them.

Advantages for physicians

With the approval of the four basic principles by the House of Delegates at their last annual meeting, a statewide screen for payment was put into place for all physicians (par and non-par) in August. You have been receiving increased payments for your services for the past six months because of this screen. This will continue under the proposal.

In addition to the statewide screen, the proposal calls for:

1. An automatic update of all profiles to a physician's current charge level.
2. An automatic annual update of physicians' profiles based on a profile limitation factor (modified CPI)
3. A financial incentive to supply medical care in a less costly outpatient setting where appropriate.
4. A payout level of 85% of the aggregate charges for physicians' services.

The total reimbursement package amounts to an increase of 12.5 percent or nearly 60 million more in payment to physicians in 1979 compared to 1978.

In addition to the reimbursement package there will be:

1. An analysis of screens to insure appropriate reimbursement levels among various procedures to reflect the degree of complexity, risk, technical and professional input.
2. A mechanism to allow physicians with charges below the screen to have a proportionately larger in-

(continued on page 172)

Doctor Crandall is chairman of the physician work group which has negotiated physicians' demands with Blue Cross/Blue Shield of Michigan.

crease each year to eliminate an ever-increasing spread of fees.

3. A modified UCR system developed for lab and pathology, low frequency services, new technology and new medical techniques.

Under the equality of treatment proposal, there will be no differential in payment for physicians' services whether they formally participate or not.

For physicians to receive the benefits in the reimbursement and equality of treatment agreement, they have certain responsibilities. First, MSMS must achieve an 80 percent level of formal participation by physicians of Michigan (currently the level of formal participation is 71-72 percent). Second, MSMS must work with BCBSM to implement the cost containment program.

Far-reaching program

Your Negotiating Committee feels this cost containment program is one of the most important and far-reaching programs the medical society has undertaken. First, it is a problem-solving system designed to identify areas of increasing health care expenditures. Rather than reduce payments in these areas, it is designed to have physicians on regional committees investigate the problems and submit solutions designed by them to address the specific problems in their areas. Second, the program is designed to train certain physicians in each region of the state to become experts in the management of health care resources in their area. It will also supply local physicians with the data necessary to make these decisions. This expertise and data can only strengthen the position of organized medicine in future negotiations with insurance companies, government agencies and HMOs.

The Negotiating Committee feels a cost containment program designed and run by physicians at a local level is far more advantageous than the alternative one administered by BSBSM employees who are not sensitive to quality medical care.

Some perceived problems

There has been a lot of misunderstanding of the program. I would like to address some of these perceived problems.

The make-up of the proposed state committee is 40 percent physicians and 60 percent consumers. This 40 percent of physicians is a significant increase in input over our current level of input into BCBSM matters.

The expenditure goal set by the state committee is a guideline to trigger an investigation of a potential problem and is not a limit of monies to be spent as the Blues' proposed Target Limitation of Expenditures (TLE) plan.

The make-up of the Regional Committee is four physicians and two consumers. The Regional Committee will have the authority to recommend actions that affect both physicians and consumers. This consumer representation is needed at the regional level if the committee wishes to educate and modify consumers' behavior in their use of health care resources.

If a region fails to correct an identified problem, the Regional Committee has the authority to recommend sanctions to both physicians and consumer groups.

The Regional Committees are based on the MSMS Councilor Districts which will allow both supervision and coordination of their activities by MSMS. There will still be one statewide screen for reimbursement for physicians, but 15 regions used to study health care expenditures in the state.

Per-case participation

Although the proposal does not specifically address the issue, it is apparent that BCBSM will very likely eliminate the "per-case" participation option. It is my understanding that this will happen, whether the proposal is approved or not. Physicians will retain their right to be "par" or "non-par." In as much as we hope to achieve 80 percent formal participation, and 95 percent of claims are on participation agreements at present, the total impact of the loss of the "per-case" option should affect relatively few physicians.

Another perceived problem area is under equal treatment of physicians. Although the proposal specifies there will be no differential in payment for "par" and "non-par" physicians, BCBSM retains the right to administer programs with this differential if negotiated by parties outside the BCBSM organization (MSMS currently has pending legal action on this issue). The mechanism of differential in payments was used as a means to stimulate a greater level of participation in the program by physicians. If MSMS achieves the 80 percent level of participation, a need for this stimulus would be lost and further programs with differentials would not be necessary.

The last perceived problem relates to BCBSM's willingness to administer the proposal in good faith. The physicians of Michigan can be reassured in this regard, as we have the options of terminating the proposal with 60 days' notice or of renegotiating the proposal at least once a year.

Time for decision

The Council of the MSMS has elected not to recommend approval of the proposal, but to poll the membership. The House of Delegates will ultimately decide for the physicians of Michigan if the proposal will be accepted or not.

Although the proposal doesn't achieve all the goals of the State Medical Society in relation to BCBSM, it goes a long way in eliminating most of the problems physicians have had with the UCR over the past several years.

It is indeed a time for decision.

The Negotiating Committee feels the physicians of Michigan should accept the challenge and approve the proposal.

by the work group that "a minority of physicians on these committees is better than none at all," is specious. There are no pictures on a scorecard — losing a vote in committee six to four is as bad as 10 to 0.

Physicians will be "sanctioned"

Although accustomed to self discipline in a well-disciplined profession, physicians will never accept loss of ability to earn a living on the basis of alleged transgressions determined by ill-defined consumer-oriented entities dubbed regional committees. The posture of the non-participating physician vs. the participating physician has become much clearer in light of the recent U.S. Supreme Court decision anent the Royal Drug Case, which urges that such disputes should be decided by courts of law and not by sanctions which result in non-payment or outright suspension of the non-participant. "Sanctions" are approbations which may function in the field of international diplomacy but not in areas of intra-professional discipline.

"Per-case participation"

The loss of per-case participation must only harm the patient most, since he will be unable to obtain care from the physician of his choice if that physician opts not to participate in an untenable pre-negotiated contract. Per-case participation was an arrangement born by a consent judgment in the circuit court, which has worked well and has benefited the consumer. It is a crucial point to most physicians, any statistical resume from Blue Cross/Blue Shield to the contrary.

Prior negotiated contracts

Prior contracts dictating *payment for care to participating physicians only* are not to be altered by anything in the present proposal. The UAW and the organizations controlled by them through the bargaining process have negotiated away many physicians' rights to determine fees and other obligations in the delivery of health care. It can be anticipated that many other such contracts will be negotiated in the future. If this is considered equality of treatment my definitions differ from those of the work group.

Fee for service concepts

The proposal alters the fee-for-service mechanism by abandoning the concept of usual, customary, and reasonable reimbursement. It is a short step to capitation payment schedules from the complex formulae for payment for care under the proposal.

Participating agreement

The proposal fails to define the real relationship between the participating physician and BCBSM. The promises of "automatic profile updates," "$60 million in total new money for reimbursement," and "equality of treatment" are false and fragile inducements to ratify the proposal. Somewhere, somehow the participating contract should have been studied and discussed. Certainly, the old covenant fails to protect the participating physician. The new program is said to allow a 60-day opt-out clause which is little comfort since it gives Blue Cross/Blue Shield 45 more days of physician servitude than the previous participating agreement. This is no substitute for the definition of a better adversary role of the participating physician group vs. BCBSM. BCBSM is an insurance business and it must function in the market place with physicians, not under the guise of a protector with special privileges.

What action is necessary?

1. Thank the negotiating committee and dismiss it at once.
2. Urge the MSMS Council to strongly disapprove the proposal if it cannot totally reject it.
3. Demand the House of Delegates meet without further delay in special session to consider the proposal.
4. If renegotiation is still viable, establish a new committee of physicians which will meet with representatives with BCBSM in the open, with continuing advice from both the profession and others experienced in negotiation and in the legal nuances of third-party problems.

This so-called proposal is not a proposal, but a sell-out. It surrenders everything for which many of us have fought over the last 25 years. It is potentially catastrophic to the delivery of health care to the citizens of Michigan. A word to the wise is sufficient.

Here is detailed information on state's proposed bed reduction plans

Editor's Note: As this article went to press negotiations were underway which may radically alter the methodology for the determination of excess hospital beds.

By Dennis Paradis
MSMS staff

The new Michigan Public Health Code (Public Act 368 of 1978) amended the Certificate of Need Law and created a process for eliminating excess hospital beds. The process specifies the time-line as well as the decision making points for the designation and elimination of excess beds.

Since this process will determine the number and location of excess hospital beds, it merits close monitoring by those concerned with health care.

The process calls for *guidelines* to determine an appropriate number of hospital beds and *criteria* to direct the decisions regarding the elimination of excess hospital beds. The guidelines and criteria were developed by the Michigan Department of Public Health and submitted to the Statewide Health Coordinating Council on 11-16-78.

The Statewide Health Coordinating Council voted to accept the guidelines and criteria (despite objections from physicians and the hospital industry) on Feb. 8, 1979. The guidelines and criteria were presented to the Joint Committee on Administrative Rules on March 6, 1979. The committee has thirty days to act on the guidelines and criteria or they are automatically approved.

The guidelines call for using the formula below to determine appropriate bed need.

The formula was developed in 1974 by the Michigan Acute Care Bed Need Methodology Project. The formula has strengths and weaknesses which are best understood by analyzing the individual components.

Projected population

The area which a hospital serves is based on the hospital's discharge data. The hospital's discharges from a zip code are computed as a percent of all hospital discharges from that zip code. The hospital is then credited with serving that percent of the total population of that zip code. This process is repeated for each zip code and added to estimate the population a hospital serves. This method permits a hospital to be credited with services provided to patients from other geographic areas. 1970 census data is the base from which the zip code data is drawn. It is updated with mid-year census figures and then projected to 1984. There is some built-in error in extrapolating from a 1970 data base to 1984, but it is the best estimate available.

Use rate

This is the key variable in determining the number of hospital beds. The formula uses the lower of the historical use rate or 1,000 non-obstetric patient days per year for each 1,000 persons served. Additional days are granted for rural areas and areas with a large elderly population. The current Michigan non-obstetric use rate is about 1,150 patient days per 1,000 persons. Nationally, non-obstetric use rates vary by state from about 920 patient days to nearly 1,650 patient days. Based on this spread, planners estimated 1,000 non-obstetric patients days was an appropriate base from which to plan hospital bed needs. There are arguments that adjustments should be made for race and the urban poor, but there is general agreement that an adjusted non-obstetric use rate of 1,000 patient days per 1,000 population is an attainable goal. The non-obstetric use rate multiplied by the population produces the target number of non-obstetric patient days per year. Dividing by 365 provides the target number of non-obstetric hospital beds.

Target occupancy rate

This is the most controversial element in the formula. Since hospital admissions fluctuate, there must be a reserve pool of beds available for times of peak admissions. Multiplication by the occupancy rate determines the size of the reserve pool. The formula in the proposed guidelines establishes a sliding occupancy rate as follows:

Adult Medical/Surgical

66% for 1-15 beds
67-73% for 16-25 beds
74-84% for 26-50 beds
85-89% for 51-75 beds
90% for 76-89 beds
91% for 90 beds or larger

Pediatric Medical/Surgical

60% for 1-19 beds
75% for 20 or more beds

$$\frac{\text{Projected Population}}{1{,}000} \times \text{Use Rate} \times \frac{1}{365} \times \frac{1}{\text{Target Occupancy Rate}}$$

OB Average Daily Census + Z Factor

Adult & Pediatric Medical/Surgical Bed Need
+
OB Bed Need
=
Hospital Bed Need for a Service Area

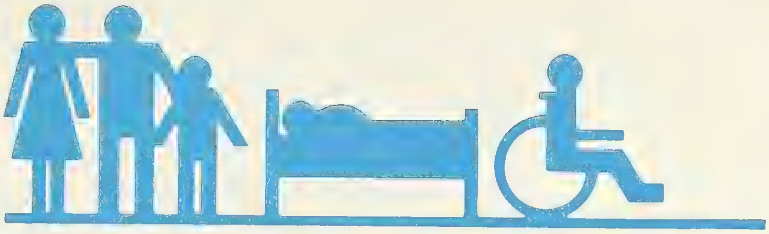
The 91 percent target occupancy rate for hospitals with more than 90 adult medical/surgical beds is the major point of contention in the proposed guidelines.

Since the reserve pool is generally empty beds, the health planning community is attempting to keep this reserve as small as possible to maximize efficiency. The hospital industry contends the target occupancy rate for adult medical/surgical beds will require a hospital to operate at more than 100 percent occupancy during weekdays, as occupancy rates drop on weekends and holidays. The following data was prepared by the staff of the Michigan Hospital Association:

To maintain a 91 percent medical/surgical occupancy rate — *

With a weekend/holiday occupancy rate of:	A hospital must maintain a weekly occupancy rate of:
65%	105.5%
70%	103%
75%	100.6%
80%	98.1%

* *Assumes 5 percent medical/surgical beds are special care beds (ICU, CCU, etc.) and occupied at 70 percent.*



TIMELINE FOR THE ELIMINATION OF EXCESS HOSPITAL BEDS

Time Frame	*Activity*	*Action*
45 Days	**MDPH prepare guidelines and criteria and submits to the SHCC**	**Submitted 11/16/78**
90 Days	**SHCC modifies/approves guidelines and criteria and send to Joint Committee on Administrative Rules**	**Approved 2/8/79**
30 Days	**Joint Committee on Administrative Rules approves guidelines and criteria or returns to SHCC for consideration**	**Submitted 3/6/79**
30 Days	**MDPH issues guidelines to draft a list of areas with more than twenty-five excess hospital beds**	
210 Days	**HSAs prepare five-year plan to eliminate excess hospital beds**	
120 Days	**SHCC modifies/approves HSA bed reduction plans**	
90 Days	**MDPH prepares a bed reduction plan if SHCC has failed to approve HSA plans**	
	Future Certificates of Need will be issued for projects consistent with bed reduction plan	

MDPH = Michigan Department of Public Health
SHCC = Statewide Health Coordinating Council
HSA = Health Systems Agency

On March 8, the MSMS Council heard a report on the proposed 91 percent occupancy rate. Fearing this occupancy level would result in a lower quality of health care due to over-crowded hospitals and difficulty in admitting patients in a timely manner, the MSMS Council voted to oppose the 91 percent target occupancy rate as, "too high and too rigid."

OB average daily census

This element is calculated by multiplying the number of births per year by the average number of days an OB patient is in the hospital (4.26 days), and dividing by 365. There is no objection to this element because it is based on actual experiences rather than a target utilization pattern.

Z factor

The "Z" factor is used to determine the appropriate size of the reserve pool of OB beds. The number is derived from a standard distribution to assure that an OB bed will be available 99 percent of the time despite normal fluctuations in OB admissions.

Future actions

After the guidelines and criteria are approved by the Joint Committee on Administrative Rules, the Michigan Department of Public Health has 30 days to apply the guidelines to the hospitals in Michigan's 71 service areas. The beds needed (as determined by the formula) will be subtracted from the licensed beds. If the difference between bed need and licensed beds shows more than 25 excess beds, the service area is put on a list for mandatory bed reduction. From the point that the list is published, the Health Systems Agencies (HSAs) have 210 days to develop a plan to eliminate the excess hospital beds.

The elimination of excess hospital beds will be an intensely debated issue from the standpoint of health planning and health politics. Physicians involvement at the HSA level is essential if the outcome of the process is to reflect the community's health care needs.

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ACUTE OTITIS MEDIA

*Involving susceptible organisms.

Please see Indications section in summary of product information on last page of this advertisement.

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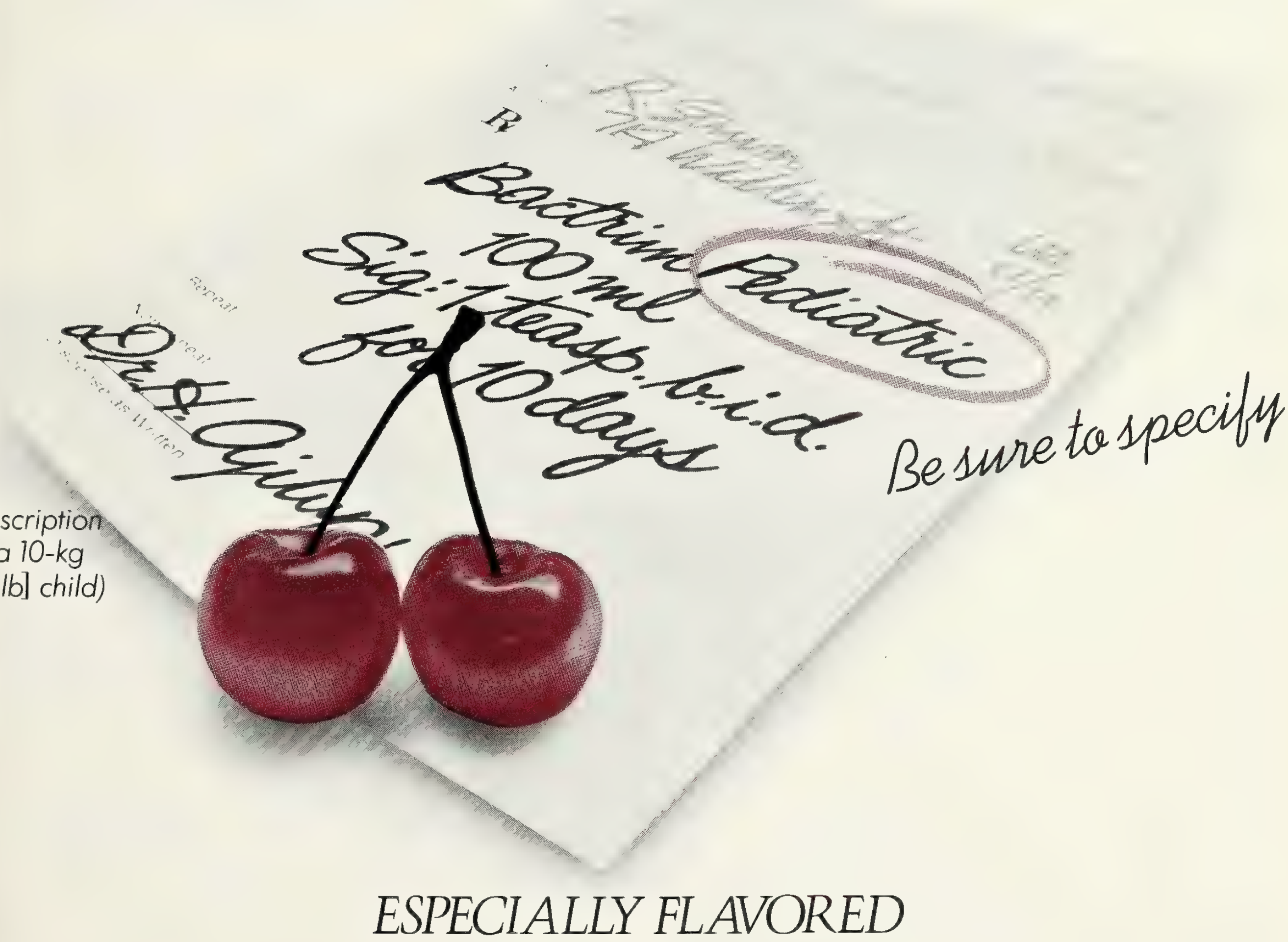

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ontraindicated in children under 2 months of age.

Please see summary of product information on following page.

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(trimethoprim and sulfamethoxazole)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides, pregnancy, nursing mothers, infants less than two months of age
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides Sore throat fever, pallor, purpura or jaundice may be early signs of serious blood disorders Frequent CBC s are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted
Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function Bactrim may prolong prothrombin time in those receiving warfarin, reassess coagulation time when administering Bactrim to these patients
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim *Blood dyscrasias* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia *Allergic reactions* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis *Gastrointestinal reactions* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis *CNS reactions* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness *Miscellaneous reactions* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L E phenomenon Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients, cross-sensitivity with these agents may exist In rats, long-term therapy with sulfonamides has produced thyroid malignancies
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN
Adults Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b i d for 10-14 days Use identical daily dosage for 5 days for shigellosis
Children Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days Use identical daily dosage for 5 days for shigellosis A guide follows
Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
22	10	1 teasp (5 ml)	½ tablet
44	20	2 teasp (10 ml)	1 tablet
66	30	3 teasp (15 ml)	1½ tablets
88	40	4 teasp (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment

Creatinine Clearance (ml min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

PNEUMOCYSTIS CARINII PNEUMONITIS Recommended dosage 20 mg kg trimethoprim and 100 mg kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days See complete product information for suggested children s dosage table
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose® packages of 100, Prescription Paks of 20 *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500 Tel-E-Dose® packages of 100, Prescription Paks of 40, available singly and in trays of 10 *Pediatric Suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, cherry flavored—bottles of 16 oz (1 pint) *Suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole fruit-licorice flavored bottles of 16 oz (1 pint)

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April, 1979 Meetings

April 4–7	**Tennessee Medical Association** Airport Milton Inn Memphis, Tennessee
April 19–21	**Alabama Medical Association** Birmingham Hyatt House, Civic Center Birmingham, Alabama
April 19–22	**Missouri State Medical Association** Chase-Park Plaza Hotel St. Louis, Missouri
April 20–22	**Georgia Medical Association** De Soto Hilton Savannah, Georgia
April 21–22	**Iowa Medical Society** Hyatt House Des Moines, Iowa
April 22–25	**Arkansas Medical Society** Little Rock Convention Center Little Rock, Arkansas
April 25–29	**Arizona Medical Association** Safari Hotel Scottsdale, Arizona
April 26–29	**South Carolina Medical Association** Myrtle Beach Hilton Myrtle Beach, South Carolina
April 29– May 2	**Nebraska Medical Association** Holiday Inn Kearney, Nebraska

Recent Michigan legal developments important to all practicing physicians

MSMS Legal Counsel A. Stewart Kerr makes the following observations about recent Michigan legal cases of importance:

Hospital staff liability

An important decision was handed down by the Michigan Supreme Court last Dec. 28. The opinion is much too long and complicated to deal with in *Michigan Medicine* but it is an important holding.

Among other things, the Court clearly holds that a hospital can be responsible for acts of malpractice on the part of physicians with staff privileges even if those physicians are not employees of the hospital and even if the physicians themselves are not found liable.

The Court's definitions of agents, servants and of the agency by estoppel are particularly interesting.

The Supreme Court made the two following major points:

1. The plaintiff's pleadings were sufficiently broad to include an allegation of the hospital's vicarious liability for the negligent actions of physicians other than the treating physician practicing medicine at the hospital as "agents" of the hospital.

Moreover, the plaintiff presented proofs of the relationship an internist with staff privileges at the hospital had with the plaintiff, and on his attempt to treat the plaintiff's shoulder at the hospital.

Finally, the trial court properly instructed the jury that the defendant hospital was under a duty to provide its patient with competent care and treatment by a person on its staff or in training at the hospital.

2. Generally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to treat his patients. However, if the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment, rather than merely as the place where his physician would treat him, an agency by estoppel can be found.

One relevant factor in this determination is whether the hospital provided the plaintiff with the physician or there was a patient-physician relationship independent of the hospital setting. There is nothing in the record of this case which should have put the plaintiff on notice that the internist, when he attempted to treat the plaintiff's shoulder, was an independent contractor.

The plaintiff's testimony shows that he went to the hospital for treatment and expected treatment from the hospital staff. The medical personnel who treated him had no pre-existing relationship with the plaintiff and were ostensibly agents of the hospital.

This is not to say that the hospital would escape liability even if the plaintiff knew or should have known of the relationship of the internist with the hospital.

Defendant's, plaintiff's rights

A second important decision was handed down by the Michigan Court of Appeals in November.

An employee was suing his employer in a personal injury case. The employee submitted to an independent medical examination by Doctor X as arranged by his employer.

The employer, or defendant, then scheduled Doctor X's deposition. But on the date scheduled for the case in court, the defendant's, or employer's, attorney met privately with Doctor X and then told the plaintiff that Doctor X's deposition would not be taken.

The employee, or plaintiff, then moved for a court order to take Doctor X's deposition. The trial court ruled that Doctor X was the defendant's witness and as the defendant did not intend to use his testimony, the plaintiff, or employee could not depose Doctor X or subpoena him for trial.

However, the Michigan Court of Appeals ruled that the plaintiff, or employee, can indeed either depose Doctor X or subpoena him as a witness for trial.

Ownership of records

MSMS members frequently ask legal counsel about the ownership of medical records.

In a recent opinion (No. 5125 of May, 1978) requested by Reps. Barbara Rose Collins, Perry Bullard and Richard Young, the attorney general reaffirmed the position legal counsel has expressed to MSMS members over the years.

That is the physician or hospital owns the physical piece of paper and also the information therein, provided however the patient also has proprietary right to the information therein.

As the attorney general says, the patient "has a right of access and a right to receive copies of information concerning his or her diagnosis or treatment . . . "

The attorney general's opinion also discusses at some length the disclosure of records of mental patients. The attorney general merely has reaffirmed the statute which provides, in pertinent part, that the records of a mental patient may be disclosed, in limited circumstances, when in the judgment of the physician or hospital record holder that disclosure would not be detrimental to the recipient or to other persons.

In short, we think the attorney general's opinion is a correct one.

Taking time and care with patients lessens risk of residents in surgery

By A. Stewart Kerr
MSMS legal counsel

MSMS members have expressed concern in this era of malpractice litigation as to the participation or scope of participation of residents in surgery.

Their anxiety is heightened by occasional reports from other states indicating that doctors and hospitals have been successfully sued for some act or omission of a resident or for the mere fact that the resident did participate in the surgery.

Close examination of these cases reveals that the principle of using a resident so to assist was not itself under attack; rather, the patient was not fully informed of the extent of that participation, the surgeon allowed the resident entirely too much latitude, or whatever.

There is no legal or factual reason why a resident should not be utilized in surgery. The resident should be introduced to the patient in advance, the patient should be told that the resident will be assisting in the operation, under close supervision.

The patient should be informed in general terms as to just what the resident will do and, importantly, that the surgeon will do the major work, the portions requiring the greatest skill and experience. Importantly, the patient should be told that the surgeon will be present at all times.

The secret to this situation is taking just a few minutes to do it right.

Disciplinary actions of the Michigan Board of Medicine

Meetings of December 6, 1978 and January 4, 1979

The following actions of the Michigan Board of Medicine are taken from official memoranda to MSMS and are not editorialized.

WILLIAM V. WHITEHORN, MD; SILVER SPRINGS, MARYLAND. Denial of license application due to non-conformance with CME statute.

GEORGE V. LE ROY, MD; PENTWATER. Denial of license application due to non-conformance with CME statute.

DANIEL LEE FINK, MD; SOUTHFIELD. Board recommended to Michigan Board of Pharmacy that Doctor Fink be issued a limited CSR.

JOSEPH W. RUCKER, MD; DETROIT. License suspended for one (1) year plus fifty (50) extra hours of CME Category I credit in OB/GYN modality. Licensee violated Section 11 (1) of the Act, i.e., a departure from, or failure to conform to minimal standards of acceptable and prevailing medical practice. Suspension effective 2/12/79.

DON R. KROHN, MD; FARMINGTON HILLS. License suspended for thirty (30) days; placed on three (3) years probation; letter of reprimand and quarterly reporting by licensee and his personal physician. Must adhere to prescribed medical regimen. Charged with being guilty of unmoral conduct. Suspension to take place sixty (60) days after service.

Medico-legal potpourri

MSMS legal counsel A. Stewart Kerr makes the following note on recent court decisions in the East and Midwest, for MSMS members' information:

1. Last fall a Kentucky court held that the Jefferson County Medical Society (Louisville) was entirely within its rights in expelling a member who had violated the principles of ethics of that Society and of the AMA.

2. In December the Indiana Court of Appeals upheld a hospital bylaws requirement that staff members have malpractice insurance. This is in line with an Arizona Supreme Court ruling in 1977.

3. In December, the New York Court of Appeals affirmed dismissal of a physician's countersuit against the patient and the patient's lawyer. The New York court's language seems virtually to foreclose such countersuits in that jurisdiction.

4. A federal court in New Jersey has reaffirmed the proposition that a psychiatric hospital patient can refuse the administration of non-emergency drugs, at least until the court can schedule hearings on the facts.

Further details are available from MSMS legal counsel, 2100 Detroit Bank and Trust Building, Detroit, 48226.

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Reye Snydrome outbreak in Michigan — Preliminary report for early 1979

By Norman S. Hayner, MD
Lansing

An outbreak of Reye syndrome (RS) has occurred in February and early March, 1979, in Michigan in association with epidemic influenza A/Brazil/11/78 (H1N1). Through March 9, 39 cases have been reported. Similar smaller clusters of RS cases have been reported from seven other states. These represent the first apparent association of an RS outbreak with type A influenza. It is the purpose of this report to describe the distribution of early 1979 RS cases in Michigan and to encourage reporting of any more cases which have not been included.

For this report RS is defined as an acute illness presenting with persistent vomiting without diarrhea and with an altered sensorium (e.g., marked listlessness, somolence, combattiveness, delirium, coma, convulsions) without localizing signs nor recent significant cerebral trauma, and with supportive laboratory findings.

Either a consistent liver biopsy of the findings of two of the following three abnormalities is considered sufficient for support of the diagnosis: (1) elevation of either or both the serum glutamic oxaloacetic transaminase (SGOT) or serum glutamic pyruvic transaminase (SGPT) to more than twice the upper limit of normal, (2) elevation of serum ammonia, and (3) prolongation of the prothrombin time (at least two seconds more than the control; i.e., to about 50 percent or less). However, when laboratory information is not available, reported apparently typical cases have been included. Likewise, "stage zero" RS (with typical laboratory findings but without neurological abnormalities) is included, although such cases are not being reported as part of national statistics. A number of interesting ,"suspect RS" cases also are being recorded but will not be included here.

RS case reports come from physicians, hospital disease control officers and others who are assisting in the early implementation of Public Act 312 of 1978 by which the legislature has designated RS, lead poisoning and other "critical health problems" to be reportable. In addition, active surveillance of major pediatric intensive care centers has been maintained during the outbreak.

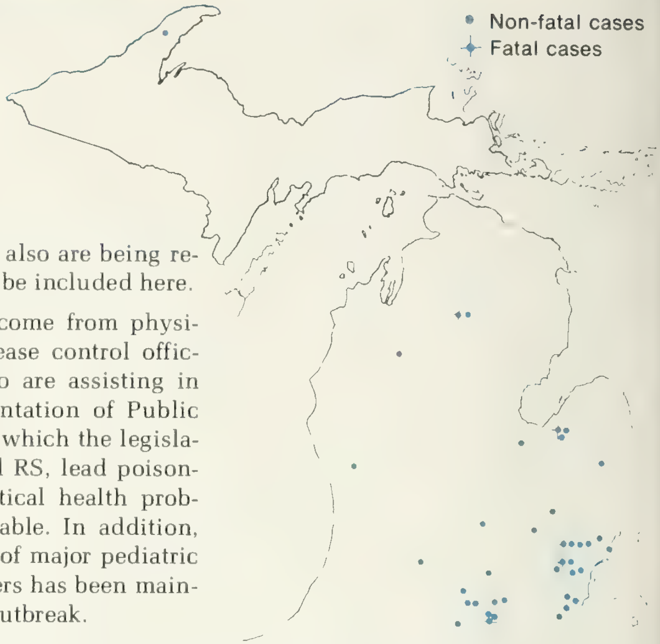
The Center for Disease Control has assisted the Michigan Department of Public Health in surveillance and is completing a case-control study of confirmed RS patients whose physicians and parents consent. In addition, with our endorsement, the University of Michigan and District Health Department No. 1 are collecting acute and convalescent bloods from about 1,100 school children in the Grayling area.

Preliminary observations

Data presented here represent a progress note on Reye syndrome reported to March 9, 1979.

In 1979, 39 cases have occurred in Michigan residents. Twenty patients have been males and 19 females. Their ages have ranged from 5 months to 17 years, distributed as follows: 0-4 years, 5; 5-9 years, 13; 10-14 years, 17; 15-17, 3.

Dates of onset of the 24 cases for whom these are known have ranged from February 1 to March 5, with an apparent peak in incidence about February 9. The geographic distribution of cases is shown in Fig. 1.



Location of Reye Syndrome cases reported.

Initial clinical information has suggested that an influenza-like illness antedated the onset of RS by two to six days in 20 patients and that chickenpox occurred shortly before one. The age-sex distribution and the progression and geographic distribution of cases have also been consistent with known activity of influenza A/Brizil/11/78 (H1N1) as shown by isolations and school absenteeism.

Only part of the RS patients have required pediatric intensive care. Five have been fatal, one of which was the child with antecedent chickenpox. Four are known to qualify as stage zero cases; some others may also.

Request for reports

In order to prevent drawing erronious conclusions, physicians are requested to report other patients with probable or suspect Reye syndrome since January 1.

Reports may be made by telephone to the local health department or preferably to the Epidemiology Division of the MDPH, (517) 373-1396; alternatively a copy of the hospital summary may be sent to the Epidemiology Division, MDPH, P.O. Box 30035, Lansing, MI 48909.

Doctor Hayner is chief, Division of Epidemiology, Michigan Department of Public Health.

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INDICATIONS: *Therapeutically,* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Michigan physicians' help needed with big push to immunize children

By M. S. Reizen, MD
Lansing

The Michigan Department of Public Health needs Michigan physicians' help!

We have too many children who are inadequately immunized. This has led to our state having one-third of the measles cases in the nation last year.

A one-time mop-up is needed to correct this situation and bring immunizations to acceptable levels. Physicians' help will be needed to provide parents with immunization records on their children and to complete the immunization of patients who are deficient.

There is growing evidence that many children have been missed by both public and private health care systems and have entered schools without the required immunizations.

Schools have become a focal point for the transmission of communicable diseases, as evidenced by the 1978 school-based measles and rubella epidemics. These outbreaks originated primarily with students in the upper grades, with epidemics of severe illness for more than 13,000 Michigan children.

Highest measles number

An effective measles vaccine was introduced 16 years ago, yet Michigan has recorded the highest measles incidence in the United States since 1976. During 1978 alone, 8,006 cases were reported in Michigan.

Rubella epidemics also erupted in many school districts during the past year. A total of 3,373 cases were reported last year despite the fact that an effective vaccine was introduced in 1969. The last major outbreak was in 1964-65; it caused as many as 20,000 stillbirths and 30,000 severely handicapped children. School children were the major contributing factor in that epidemic.

A recent survey of the immunization levels of more than 1,500 Michigan preschool children as well as the annual survey of 135,000 kindergarten children indicate the distinct possibility of polio, diphtheria and whooping cough outbreaks. We must not let these outbreaks occur!

To facilitate the correction of the problem, the Michigan departments of Public Health and Education have asked local health departments and schools to strictly enforce the new immunization law and to assess the immunization records of every student in public and private, primary and secondary schools.

This will be an enormous task complicated by the fact that most records for students in secondary schools are either incomplete or entirely absent. However, it is the only reasonable way to identify the individual vaccine deficiencies of each student.

This mop-up combined with the enforcement of the law requiring all children to present immunization records before entering kindergarten should eliminate the problem for the future.

Each county has been asked to develop its own program within the broad framework of the state plan. We have suggested that an initial assessment be conducted in March using the following minimum standards:

3 Diphtheria and tetanus toxoids
3 Polio
1 Measles (administered after 1 year of age)
1 Rubella

(It should be stressed that these are minimum standards rather than recommended immunization levels and many health departments and physicians may choose to request additional vaccines.)

Physicians will be contacted

Parents of children lacking one or more of these vaccines will be asked for written records. Private physicians can anticipate calls from anxious parents. We request your patience and understanding. This will be a one-time effort and upon its successful completion our schools and communities will be much better protected against these preventable diseases.

Appropriate catch-up immunization programs will be developed. Children will be referred to their private physicians or offered vaccines in expanded public programs during the spring and summer months. Our goal is to have essentially all pupils meet or exceed the stated minimum immunization standards by the beginning of the next school year.

An evaluation of this program's effectiveness will be conducted upon its completion next fall. We will share our findings with you by January of 1980.

I would like to extend my sincere thanks for your cooperation in this effort. With your help, we intend to make our schools a safer environment for their primary purpose: the education of children.

Doctor Reizen is director, Michigan Department of Public Health.

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THE LEADING NATIONAL BRAND OF GENERICS

Auxilians' money, manpower, materials continuously flow to other nations

Mrs. Jones

By Anita Yannitelli
Battle Creek

In 1961, AMA-A established a program to offer service to the worldwide medical community. This international health program now has two main functions: to provide hospitality to foreign doctors studying in US hospitals, and to collect medical discards in pharmaceuticals, equipment and eyeglasses for distribution to those in need.

Today the program includes 17 major international health agencies with separate administrative offices and serving particular areas of the world. In addition, others function on a smaller scale and are approved by county medical societies.

International health projects are outlets for the medical auxiliary's philanthropic services. Auxilians support them through gifts of money, manpower, material and medical assistance.

Scholarships, books

Among the 17 major agencies are the following:

Scholarships for Kids of International Physicians, (SKIP), is one project of MAP, Medical Assistance Programs, Inc. Money is used to help with the education of physicians' children in those places (primarily India) where doctors are assuming positions in small hospitals or clinics and where no educational facilities are available. MAP established the program to assist these medical missionaries. AMA-A national board allots money directly to the SKIP program each year.

The International Book Project, Inc., (IBP), based in Lexington, KY, arranges for books and technical journals no longer needed here to be sent to those in underserved countries. Books and magazines, when recycled through the minds of people, benefit the donor and recipient.

Project HOPE, based in Washington, DC, has given 20 years of service to its programs which bring medical education and better health to people around the world. HOPE operates in the US and 12 other countries and is known as a People-to-People Foundation. HOPE trains rural health nurses in developing areas, trains physicians in vital techniques of community medicine and provides home visits by public health nurses counseling on hygiene, nutrition and family planning.

Some county auxiliaries collect used eyeglasses which are carefully checked and then sent to dedicated physicians in other countries for fitting. Several Michigan physicians and their wives give medical and surgical aid in Honduras and take with them all the eyeglasses auxilians can collect.

New Eyes for the Needy in Short Hills, NJ, and World Medical Relief include glasses on their lists of needs.

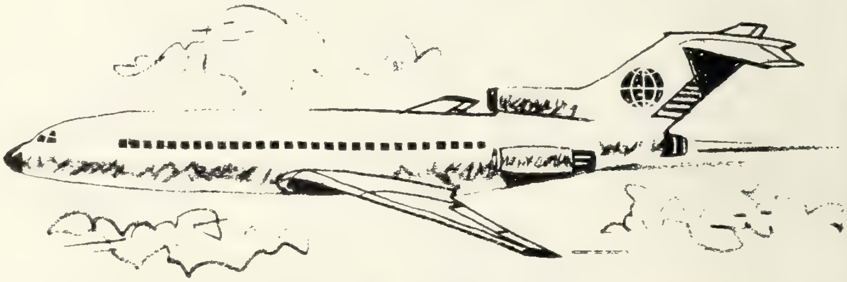
World Medical Relief

Twenty-five years ago an Army chaplain appeared on television seeking clothing for Korean orphans. Mrs. Irene Auberlin, Detroit, answered his call. That was the start of World Medical Relief. At age 82, Mrs. Auberlin still is actively involved with the program, which she directs as president.

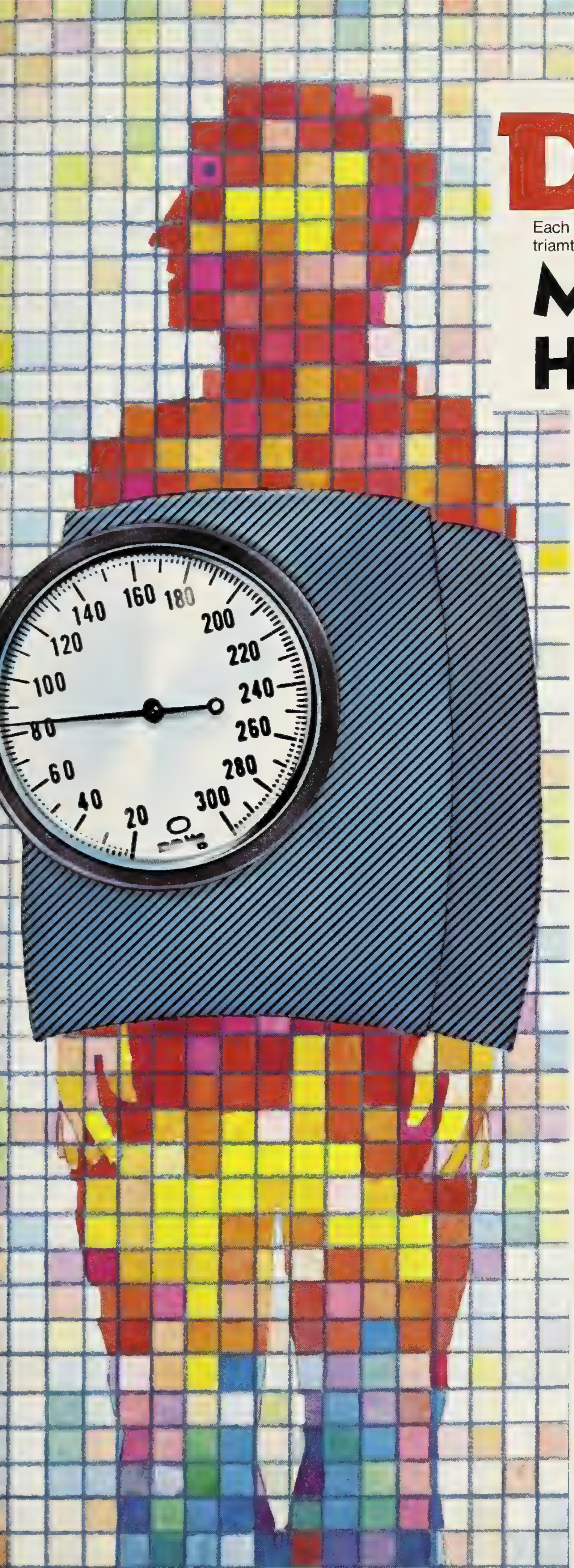
In 1953, Mrs. Auberlin stated, "World Medical Relief was founded as a means of sharing this nation's medical crumbs with the sick and needy of a suffering world." Medical auxilians have supported WMR with donations of pharmaceuticals and equipment from physicians' offices, hygiene kits, afghans, sheets and other needed articles through the years.

To date, WMR has collected and recycled over $250 million worth of drugs and medical supplies. They have primarily been solicited from the American medical group.

Mrs. William J. Jones, past MSMS-A president, is presently International Health chairman for the auxiliary state board. For further information, she may be contacted through the MSMS Special Services office.



Mrs. Yannitelli is editor of the MSMS/A newsletter, **Auxilium.**



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Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR.* A brief summary follows:

> * **Warning**
> This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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10 mg. capsules, 20 mg. tablets,
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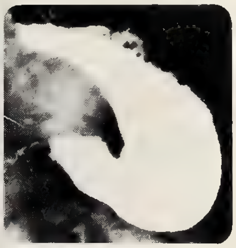
helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS. Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with Autonomic neuropathy Hepatic or renal disease Ulcerative colitis Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition

Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur. ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia; urinary hesitancy and retention, blurred vision and tachycardia; palpitations; mydriasis; cycloplegia, increased ocular tension; loss of taste; headache; nervousness, drowsiness, weakness, dizziness, insomnia, nausea; vomiting; impotence, suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs

Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily. *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg : *Adults* 1 tablet three or four times daily Bentyl Injection. *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used

Product Information as of October, 1978

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U S A

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson Merrell Inc
Cincinnati Ohio 45215 U S A

Meetings

April 10 — MSMS Auxiliary Legislative Day, Kellogg Center, East Lansing, contact: Helen Schulte, MSMS headquarters.

April 12 — MSMS Conference on Medical Aspects of Organized Athletics, Towsley Center, Ann Arbor, contact: Mert Scholten, MSMS headquarters.

April 26-29 — Medical Assistants State Convention, Lansing, contact: Helen Schulte, MSMS headquarters.

May 4-6 — MSMS Auxiliary Annual Convention, Sheraton Inn, Kalamazoo, contact: Helen Schulte, MSMS headquarters.

May 4-5-6 — MSMS House of Delegates, Kalamazoo Center Inn, Kalamazoo, contact: Richard Campau, MSMS headquarters.

July 5-8 — MSMS Council, Birchwood Farm Golf & Country Club, Harbor Springs, contact: Warren Tryloff, MSMS headquarters.

July 22-26 — AMA Annual Meeting, Chicago Marriott Hotel, contact: AMA headquarters, 312/751-6000.

Sept. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters: 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other Meetings

June 15-19 — Association for Behavior Analysis 5th Annual Convention, Hyatt Regency Dearborn, contact: ABA Program Committee, Dept. of Psychology, Western Michigan University, Kalamazoo 49008. 616/383-1629.

July 7-12 — Annual meeting, Michigan Academy of Family Physicians, Holiday Inn, Traverse City.

Medical Necessity Program growing Blue Shield cost plan

By Robert D. Young
Detroit

You already may have heard of the Blue Shield Association's announcement of its Medical Necessity Program which is designed to upgrade the quality of medical care. BCBSM now will pay for certain surgical and diagnostic procedures only upon written justification by the physician. These procedures have been classified into the following categories:

1. New procedures of unproven value.
2. Established procedures of questionable current usefulness.
3. Procedures that tend to be redundant when performed in combination with other procedures.
4. Procedures that are unlikely to yield additional information through repetition.

The program is the result of a cooperative effort begun more than one year ago by the Blue Shield Association, the American College of Physicians, the American College of Surgeons, the American College of Radiology, the American Academy of Family Practice, the Council of Medical Specialties, the American Association of Medical Colleges, and the American Hospital Association.

It is anticipated the program nationwide will save Blue Shield subscribers upwards of $27.4 million.

The Medical Necessity Program became effective in Michigan in July, 1978. The initial announcements on the program were made in BCBSM's April, May and June *Record*. Although utilization of the specific procedures is not unusually high in Michigan we do anticipate this as a first step in identifying and eliminating unnecessary health care expenditures.

The specific procedures of the Medical Necessity Program have been reviewed and categorized into the following three groups.

Please turn the page for charts presenting three categories of procedures which fall under Blue Cross/Blue Shield Medical Necessity Program.

Mr. Young is Special Projects Coordinator, Utilization Review, Blue Cross/Blue Shield of Michigan.

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(1) Procedures requiring justification when performed at anytime:

Procedure Code	Description
2193	Bronchoscopy, Diagnostic with Insertion of Radioactive Substance
2725	Ligation of Internal Mammary Arteries, Unilateral
2726	Ligation of Internal Mammary Arteries, Bilateral
3522	Hemorrhoidectomy, Radical, Whitehead Type, Including Removal of Pile Bearing Area

Procedure Code	Description
3778	Omentopexy for Establishing Collateral Circulation in Portal Obstruction
3834	Decapsulation, Kidney Unilateral
3835	Decapsulation, Kidney Bilateral
3875	Nephropexy: Fixation of Suspension of Kidney, Unilateral
4500	Circumcision (female)
4671	Hysterotomy, Non-Obstetrical Vaginal
4686	Supracervical Hysterectomy: Subtotal Hysterectomy, with or without Tubes and/or Ovaries, One or Both
4720	Uterine Suspension, with or without Shortening of Round Ligaments, with or without Tubes and/or Ovaries, One or Both
4721	Uterine Suspension, with or without Shortening of Round Ligaments, with or without Shortening of Sacro-Uterine Ligaments, with Pre-Sacral Sympathectomy
4960	Ligation of Thyroid Arteries
5258	Hypogastric or Pre-Sacral Neurectomy
7464	Angiocardiography. CO2 or Positive Contrast
7471	Angiography, Coronary, Unilateral Selective Injection

In the light of continued publicity about the Medical Necssity Program, Mr. Young adds it will continue to be expanded. Some 26 new procedures have been added since the lists above were prepared. Please watch *Michigan Medicine* for further details.

(2) Procedures requiring justification when performed for the specific diagnostic condition listed:

Procedure Code	Description	Diagnostic Qualifier
1720	Fascia Lata by Stripper	Low Back Pain
1721	Fascia Lata by Stripper by incision and Area Exposure with Removal of Sheet	Low Back Pain
2690	Ligation of Femoral Vein — Unilateral	Post-Phlebitic Syndrome
2691	Ligation of Femoral Vein — Bilateral	Post-Phlebitic Syndrome
4980	Excision of Carotid Body Tumor, without Excision of Carotid Artery	Asthma
4981	Excision of Carotid Body Tumor, with Excision of Carotid Artery	Asthma
5255	Sympathectomy, Thoracolumbar, Unilateral	Hypertension
5256	Sympathectomy, Thoracolumbar, Bilateral	Hypertension
5260	Sympathectomy, Lumbar, Unilateral	Hypertension
5261	Sympathectomy, Lumbar, Bilateral	Hypertension
5265	Splanchnicectomy, Unilateral	Hypertension
5266	Splanchnicectomy, Bilateral	Hypertension

(3) Obsolete medical procedures requiring justification when performed at any time.

Procedure Code	Description
8224	Thyroid, Protein-Bound Iodine (PBI), Blood
8240	Icterus Index, Blood
8950	Basal Metabolic Rate

When appropriate rationale is provided to justify the procedures, they will be reimbursed. Even though the cost of these procedures represents only a small fraction of total Michigan medical care expenditures, this marks the start of a far reaching program which we hope will have an impact on cost while maintaining quality of care.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

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REFER TO PDR

Donated eyes used in research if unsuitable for transplant

By Betty L. Herring
Special to **Michigan Medicine**

Not every eye donated to the Michigan Eye-Bank (MEB) meets that organization's high standards for keratoplasty or other therapeutic uses. But even surgically-unsuitable eye tissue is giving researchers a better view of physical disorders.

Many of their projects enable science to take a closer look at various ocular diseases and traumas. In addition, certain portions of the eye are uniquely valuable in gaining insight into problems dealing with other body tissues and functions.

Current research at Wayne State University looks to corneas, specifically the stroma, to facilitate studies involving collagen structure and synthesis. These studies are applied to diseases of the connective tissues and are being conducted under the direction of Mauricio A. Lande, PhD, of the WSU Department of Anatomy.

Although he also uses skin and other connective tissues in his studies, Doctor Lande says he finds the stroma to be especially valuable, not only because the cornea is transparent, which makes the changes more visible, but because it is avascular. That characteristic simplifies the simulation of normal life conditions in the tissue culture medium. At the same time, a high degree of accuracy is possible, he adds.

U of M projects

At the University of Michigan, a joint project involving the departments of ophthalmology, rheumatology, pediatrics and immunology is aimed at determining the antigenicity of the various parts of the eye. Doctor Meyer explains that one purpose of these studies is to try to predict, pre-operatively, the degree of risk a specific patient might incur relative to rejection or immune problems following keratoplasty.

Roger F. Meyer, MD, medical director, University of Michigan director of the MEB, with the assistance of his laboratory technologist, Kathryn C. Bobb, BA, recently completed and published the results of research establishing the validity of monitoring intraocular pressure through a therapeutic contact lens.

This study required the use of eye-bank eyes, in which, by using a canula and a mercury manometer, the researchers induced various levels of intraocular pressure. They would then check the pressure through the therapeutic lens and compare the result with the manometrically controlled reading. In this way, they developed a reliability curve for intraocular pressure on a well-controlled, graded series of pressures ranging from 10 to 50 millimeters of mercury.

"We found that we could, indeed, measure intraocular pressure with relative accuracy through a therapeutic contact lens," Doctor Meyer says.

These findings are of great value, particularly in the post-operative care of aphakic patients after penetrating keratoplasty. That group runs a higher-than-average risk of post-operative glaucoma, he says.

WSU projects

John W. Cowden, MD, medical director of the Wayne State University Division of the MEB, is conducting a major study regarding HLA antigen typing. This tissue typing research is designed to be conducted over a three-year period, but is limited because of the inadequate supply of corneal material with which to work, he says.

Another area of special interest to Doctor Cowden is study of the corneal endothelium. He also has been involved in studies to improve methods of tissue preservation and screening. He hopes the result will be an even higher percentage of surgically-useful eye tissue.

In addition to his own studies, he is cooperating with other researchers in the Detroit area who are using choroid tissue in probing the challenge of retinitis pigmentosa, using eye-bank globes in studies of the effects of laser surgery on the cornea, and studying morphology, physiology and biochemistry of both normal and cataract lenses.

While the MEB is in ever-increasing need of surgically suitable eye tissue, every eye is important to the total program. Diseased eyes, or those that for various reasons are not suitable for surgical uses, also are a very valuable contribution, Doctor Meyer emphasizes.

"And we are *very* anxious to get eyes from donors who had had previous eye surgery," he says. "There is a tremendous amount that can be learned by studying these eyes histologically in the pathology laboratory.

"We are interested in patients who have had all types of eye surgery — keratoplasty, cataract surgery, glaucoma surgery — any type. The study of postoperative ocular tissue is very important and medical science doesn't get that opportunity very often. That kind of tissue can bring about incredible strides in medical knowledge," Doctor Meyer says.

The attending physician is in a key position to further the success and growth of the eye-bank program, Doctor Cowden points out. By mentioning the Michigan Eye-Bank to patients and asking next-of-kin to grant permission for the deceased to become an eye donor, physicians are actively participating in bestowing the gift of sight and contributing to medical advancement.

This is the second in a two-part series of articles on the organization and need for eye donations in Michigan. The first appeared in the January issue of *Michigan Medicine.*

Careful Michigan procedures screen donor eyes for any disease

By John W. Cowden, MD
Detroit

Michigan Eye-Banking procedures have, for the past three years, emphasized careful screening of the records of donors for any known or suspected communicable disease which might be transferred to the recipient. This practice helps to eliminate any possibility of the transfer of disease from the donor to the recipient, such as may have occurred in two recent corneal transplant recipient deaths, one in Idaho of rabies and the other in New York City of Jakob Creutzfeldt disease. These two deaths are believed to have been due, in each case, to a virus which may have been transmitted from the donor.

Although all donor tissue is collected, no matter what the cause of death, only known healthy tissue is utilized for transplantation. The other tissue, which might be potentially hazardous or damaged by prior ocular disease or surgery, is utilized for research or training purposes.

Two Michigan Eye-Bank laboratories, one at The University of Michigan and the other at Wayne State University, are responsible for the examination, processing and redistribution of tissue for corneal transplantation.

Contradictions for transplants

The conditions which are absolute contradictions for corneal tissue to be utilized for corneal transplantation include septicemia, viremia, acute or chronic debilitating neurologic diseases which have, or are suspected of having, a viral etiology, syphilis and acute leukemia. Relative contradictions to the use of tissue for transplantation include fever of unknown origin, jaundice, unknown cause of death, excessive time from death to enucleation and extended time on life support systems. Some ophthalmologists prefer not to use tissue from very elderly donors or from donors who have had metastatic cancer.

When donor eyes are received by the eye-bank laboratory, a careful review of the cause of death and associated health conditions of the donor is made prior to examination of the ocular tissue. Often it is necessary to telephone the hospital or doctor of the donor to obtain further information in order to decide if the tissue can be used for transplantation.

A microscopic examination of the corneal tissue is undertaken and, if suitable, most corneas are placed in the McCarey-Kaufmann tissue culture media for intermediate corneal storage for up to four days if they are not to be transplanted immediately. Since the advent of the tissue culture storage method, it has been possible to utilize more corneal tissue because of the increased time allowed for investigation into suitability of tissue, obtaining culture results and contacting ophthalmic surgeons and their potential recipients to arrange for the corneal transplantation.

Corneal transplant record

Since the merger of the two branches of the Michigan Eye-Bank in 1971, there have been 1,504 corneal transplants performed with tissue processed by one or the other of the two divisions without any reported complications relating to the possible transmission of disease from the donor to the recipient.

It is hoped the awareness of the possibility of serious complications being transmitted by corneal transplantation will not result in a setback for eye-banking and corneal transplantation, but act as a stimulus for greater scrutiny and care in the procedures utilized to provide safe, healthy tissue for restoration of sight.

Doctor Cowden is medical director, WSU Division, Michigan Eye Bank.

He's retiring, this physician gently informs his patients

(Michigan Medicine *reprints the following, with permission, as an example of one physician's especially warm approach to closing his long-time practice.)*

To all my Patients:

As you may have heard, my last day in the office will be soon.

Raymond Py, M.D. of Vermillion, Ohio, will be opening an office in Bellaire, but cannot be here for two months or so after I leave. His office will be in the new building just south of Meadow Brook, my records will be transferred to his office at that time; and Barbara Jo will probably be working for him.

Dr. Py (who is of French ancestry), has practiced for about twenty years in his home town of Vermillion. He and his wife know this area and love it, and I believe his philosophy of medicine and mine are similar.

You will find that whomever you go to will have professional charges higher than mine have been, but don't let that upset you. Professional insurance costs have sky-rocketed, and all other expenses connected with a physician's practice have steadily risen with inflation. I should have raised my fees some years ago, but as my children were out of college, and my retirement plans made, I did not do so, since I knew that all of us were having problems with inflation. But a younger doctor than I can't do that.

It has been a privilege to take care of all of you and your families over the years: for some of you, that means twenty, thirty, forty or more. I have viewed this for us all not only as a doctor-patient relationship, but as one of friendship.

We shall not be leaving the area for a few months, but as we do, Mrs. Rodger and I are wishing the very best for each of you — and may God bless you all.

John R. Rodger, MD
Bellaire

Correctional Medicine

Challenging opportunities in primary health care — available in a most efficiently designed prison health care system — excellent climate — competitive salaries.

Employment available in the Spring of 1979 (April-June). 93 positions available for:

- Physicians
- Dentists
- Psychiatrists
- Physician's Assistants
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- Armed Forces
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- Dental Technicians
- Psychologists
- Health Administrators

Must be eligible for Oklahoma Licensure.

Contact:

Armond H. Start, M.D., M.P.H.
Medical Director
Oklahoma Department of Corrections
3400 North Eastern
Oklahoma City, Oklahoma 73111

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

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In treating irritable bowel syndrome*

Enhance your therapeutic expectations with Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

antianxiety/antispasmodic/antimotility

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM® (chlordiazepoxide HCl) as well as the potent antispasmodic and antimotility actions of QUARZAN® (clidinium Br) for adjunctive therapy of irritable bowel syndrome.

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions. However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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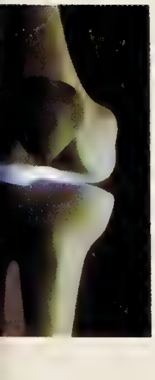
RHEUMATOLOG



Motrin 400 mg TABLETS

ibuprofen, Upjohn

The confidence that comes from experience—one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

J-6857-4

The confidence that comes from experience—
one more reason to prescribe

Motrin 400 mg TABLETS
ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)	
Bottles of 60	NDC 0009-0733-01
Bottles of 500	NDC 0009-0733-02
Motrin Tablets, 400 mg (orange)	
Bottles of 60	NDC 0009-0750-01
Bottles of 500	NDC 0009-0750-02
Unit-dose package of 100	NDC 0009-0750-06
Unit of Use bottles of 120	NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

NIM-3

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ALDOMET®
(METHYLDOPA|MSD)
TABLETS: 500 mg, 250 mg, and 125 mg

MSD
MERCK
SHARP &
DOHME

MATERNAL HEALTH DESK REFERENCE CARD NO. 23

(Presented by the MSMS Committee on Maternal and Perinatal Health)

SEPTIC ABORTION

A. Definition

A Septic Abortion is a threatened, inevitable or incomplete abortion complicated by infection as manifested by significant temperature elevation and/or a grossly purulent discharge from the cervix.

B. Diagnosis

1. Temperature, pulse, and respiratory rates are elevated.
2. Blood pressure is normal with increased pulse pressure.
3. Abdominal examination may or may not show evidence of pelvic peritonitis with uterine enlargement.
4. Pelvic examination findings may vary. The cervix may be dilated and exude a bloody, purulent discharge, or may be closed with a scant discharge, clearly purulent only on microscopic examination.
5. The following determinations should be done:
   a. Repeated vital signs
   b. Complete blood count and coagulation profile.
   c. Urinalysis (Indwelling catheter should be used for recording urinary output)
   d. Aerobic and anaerobic cultures of cervix
   e. Direct smear and gram stain from the endocervix
   f. X-ray of the abdomen for foreign bodies and the presence of free gas.

C. Management

1. Parenteral antibiotic therapy providing coverage against gram positive and gram negative aerobic and anaerobic organisms. Current recommendations would include:
   a. Aqueous procaine penicillin, 40 million units per 24 hours, intravenously, or with penicillin allergy, cephalothin 1-2 grams intravenously, every 6 hours
   b. Gentamicin, 5 mg/k/day, maximum of 240 to 300 mg/day, in three divided doses
   c. (Clindamycin, 600 mg intravenously every 6 hours or chloramphenicol, 50 mg/k/day in four divided doses intravenously if severe or unresponsive case) Toxicity of these drugs (clindamycin and chloramphenicol) should be considered.

   Daily CBC, reticulocyte count, and serum creatinine measurements are important means of monitoring possible bone marrow and renal effects of medications. Clindamycin should be discontinued with the appearance of significant diarrhea.
2. Uterine curettage should be performed as soon as adequate antibiotic coverage has been attained.
3. Adequate supportive measures consisting of fluid, electrolyte, and blood administration should be employed.
4. Administration of Rho (D) immune globulin (RhoGAM), when appropriate, is recommended.
5. The use of oxytocics in selected cases may be beneficial.

This card is a corrected version. Please discard earlier card number 23 printed with December, 1978 *Michigan Medicine.*

SEPTIC ABORTION WITH ENDOTOXIC SHOCK

A. Definition

The coexistence of septic abortion as earlier defined and shock in the absence of evidence of excessive blood loss.

B. Etiology

Shock results from the direct effect on the intracellular body compartment of bacterial endotoxins from gram positive or gram negative organisms. Multiple organisms may be involved and the syndrome may be combined with hypovolemia due to blood loss.

C. Pathogenesis

Endotoxin generates cell destruction and death. An individual exposed to a massive dose of endotoxin is destined to succumb independent of the therapy applied. In a patient exposed to a smaller dose with prompt treatment, the same therapy may clearly be of value.

The major pathophysiologic elements consist of the following:

1. Vascular pooling, especially in the mesenteric circuits, with resultant decreased cardiac output and decreased tissue perfusion.
2. Pulmonary venular constriction rendering the patient sensitive to the risk of pulmonary edema from excessive intravenous fluid administration.
3. Sensitization of baroreceptors to arterial pressure stimuli resulting in increased sympathetic activity.
4. Subsequent apparently dose-related decrease in central sympathetic activity with loss of the enhanced adrenal secretion and vasodilation characteristic of item 3.

D. Management

1. The diagnostic and therapeutic measures described for septic abortion should be performed.
2. A Central Venous Pressure (CVP) catheter should be inserted in the superior vena cava or the right atrium and its position confirmed.
   a. If CVP is normal (6-12 cm of water), the patient is functionally normovolemic and intravenous fluid should be given with care.
   b. If CVP is elevated (greater than 12 cm of water), the patient is at risk of cardiac failure.
   c. If CVP is low (less than 6 cm of water), give 500 ml of electrolyte solution per 30 minutes, measuring CVP after each 100 ml infused. When CVP rises, use caution in subsequent intravenous fluid administration.
3. The following chemical determinations constitute a useful baseline:
   a. BUN, creatinine
   b. Serum Na, K, Cl, CO_2
   c. Blood pH, blood gases
   d. Blood and urine held for toxicology.

E. Therapy

1. Primary
   a. Use antibiotic and supportive therapy as described previously.
   b. Evacuate the uterus after initiating supportive therapy. Use uterine evacuation, preferably by suction, unless the process is extended beyond the myometrium, in which case hysterectomy is needed. While uncommon, clostridial infection may necessitate hysterectomy.
2. Supportive
   a. Replace volume with blood, plasma, or electrolytes sufficient to maintain normal venous pressure.
   b. Adrenocorticoids appear to decrease cellular damage by endotoxin. Give a large initial dose (methylprednisolone 2 gm, hydrocortisone 8 gm, or prednisone 2 gm) and maintain intermittent therapy at intervals of 2-4 hours.

This Card prepared by Thomas Kirschbaum, MD. *(9-78)*

The Great Laxative Escape

COLACE®

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Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

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This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoonful (15 ml) liquid contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of branchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema
Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.
Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Liquid in bottles of 1 pint and 1 gallon.
See package insert for complete prescribing information.

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Physicians needed full time as MD advocates, planners, fiscal reps

By James D. Fryfogle, MD
Southfield

The following comments by an experienced physician and health planner are of value to physicians on hospital staffs throughout Michigan. They are excerpted from a recent talk made to the medical staff of Providence Hospital, Southfield.

Our hospital today is a business.

It is the center of our community's health needs. It is the educational hub of clinical learning for medical and paramedical personnel. Its lighted parking lots and emergency room make it the recipient of the suffering from the slightest hurt to highway carnage.

Fear, depression, rape, mayhem, and drug abuse are sorted out and treated. Expectant mothers, failing hearts, strokes, hemorrhage, fevers and broken bones enter its doors, expecting to be cared for — and they are.

Many of the hospital's marketing skills are directed at out-patients to insure a cash flow to match its predetermined, government-ordered budget.

Medical staffs changing?

The hospital has paid chiefs in the major service areas and sub-chiefs to support the educational programs, and many more young, aggressive administrators who are looking to expand the hospital's business (profit).

The world of medicine is changing. The hospital is changing, but the medical staffs, are we changing?

Organizations like ours identify with our tradition, rather than our future. Everyone is too busy to worry about change. Organizations like ours resist change.

Yet our very survival depends upon our ability to cope with change and participate in the shaping of change.

Is there any better reason to believe this is so than the following:

In 1965, the Medicare Law said, "Federal officials have no authority to intervene in the practice of medicine or the administration of Health Facilities." The 1974 National Health Planning Act says "The Federal Government *must* intervene."

I applaud the hospitals' actions to change. They have accepted their new role as a business. They have hired administrative personnel to handle new demands made on them by government and by the public. They have insured themselves against malpractice as a unit, and have sought new ways of creating money to pay for these changes.

While I neither approve, nor agree, with many of their actions, I applaud their efforts to cope with these changes.

But we, the medical staff, have done little more than what is forced upon us.

Maybe we don't think of the medical staff as a *business*. But a position on this medical staff has immense economic value. It identifies us to patients as having privileges at the "best" hospital in the community. It provides the tools, the beds, and the facilities we couldn't afford and couldn't practice without.

Plan for future

I believe *it is better to plan for the future than to accept the results of unanticipated consequences.*

Part of the planning will be done by doctors in formal meetings. I believe we ought to prepare ourselves by increasing our knowledge of parliamentary procedures. A surgeon who doesn't know anatomy is a poor operator. A doctor in committee, or in formal hearings, has to know the rules of procedure and the language or he is ineffective.

Medical staffs, acting as units, could be contracting their services. We might be forced to function as an HMO to survive economically. I can visualize negotiations with the government, with hospital administration, and with HMOs.

I think it would be good staff business to send some of our members to the negotiating sessions being held about the country. I think we spend time on educational programs for residents and little on ourselves. And all of this costs money. Where does this money come from?

Well, we can do as the hospital does, start a staff service and contribute those fees. Since we are no longer captains of the ship, it is not necessary that we *give* our time to the chores needed by the hospital and the Board of Trustees. The new payment measures for physicians doing government work (PSRO, utilization, etc.) demonstrate that we are worth an hourly fee.

We need legal advice, and, to be sure, competent staff for each committee.

Lastly, a mistake we've already made is to entrust this growing, changing staff business to part-time volunteers like me whose first obligations have to be to their patients.

We ought to consider, seriously, directors of medical affairs who could be sure that we are represented on the local health planning board, who would be our worriers, our expediters, our advocates, our fiscal intermediaries — who could be vigilant and vocal about medical staff business.

Doctor Fryfogle is president of the Providence Hospital medical staff, and is speaker of the MSMS House of Delegates. Recognizing the immense implications of the federal health planning act before it became popular knowledge, Dr. Fryfogle personally organized and recruited members of the so-called "Seven County Committee," forerunner of the current MSMS Physician/HSA Support Center.

Blues using money to fragment medical profession

By Louis E. Heideman, MD
MSMS president

It is unfortunate that we are faced with a divisive issue at a time when unity within the medical profession is essential. It also is unfortunate that that issue, ultimately, is money.

There is nothing wrong with money, or the expectation of a fair payment for an adequate service. But when it becomes the primary concern and focus for decision-making over our commitment to the provision of health care in a manner and under terms acceptable to our patients, our cause is lost.

As I look at our present situation, money is being utilized by outside sources in an attempt to fragment our profession, rendering it impotent and ineffective.

Efforts to control

The modification of the psychiatry programs, the hearing aid program, and the eye glass program, can be easily construed as efforts to pick off and control relatively small components of our profession.

The proposals to change payment mechanisms for the radiologists, pathologists, and anaesthesiologists in hospital practice are of the same genre. They originate from a single source, are presented in two forums — BCBSM and the Statewide Health Coordinating Council and again are aimed at small segments of our profession which have special problems and susceptibilities and impose the ultimate goal — salaried practice for all physicians.

The radiologists feel so threatened, so insecure, and abandoned by the rest of the profession that they have levied a special assessment. This is being utilized to obtain legal counsel and to obtain independent legislative lobbying support, the latter at an expenditure of $25,000 a year. The unhappy reality is that this has the potential of our unknowingly working at cross purposes, with the loss of their cause and the destruction of medicine.

Please see special section this issue, pages 169-173.

We have been in conflict with Blue Cross and Blue Shield (now BCBSM) for many years over a variety of issues with generally increasing ill-will.

We have forgotten why these organizations came into existence, have not consistently recognized their legitimate needs (as they haven't recognized ours) and have not looked at the alternatives should BCBCM disappear. The most likely alternative, in my opinion, is a state or federally operated substitute. The Blues came into existence to avoid this. Is the alternative to the Blues any more acceptable now that it was in 1939?

Agreement unacceptable

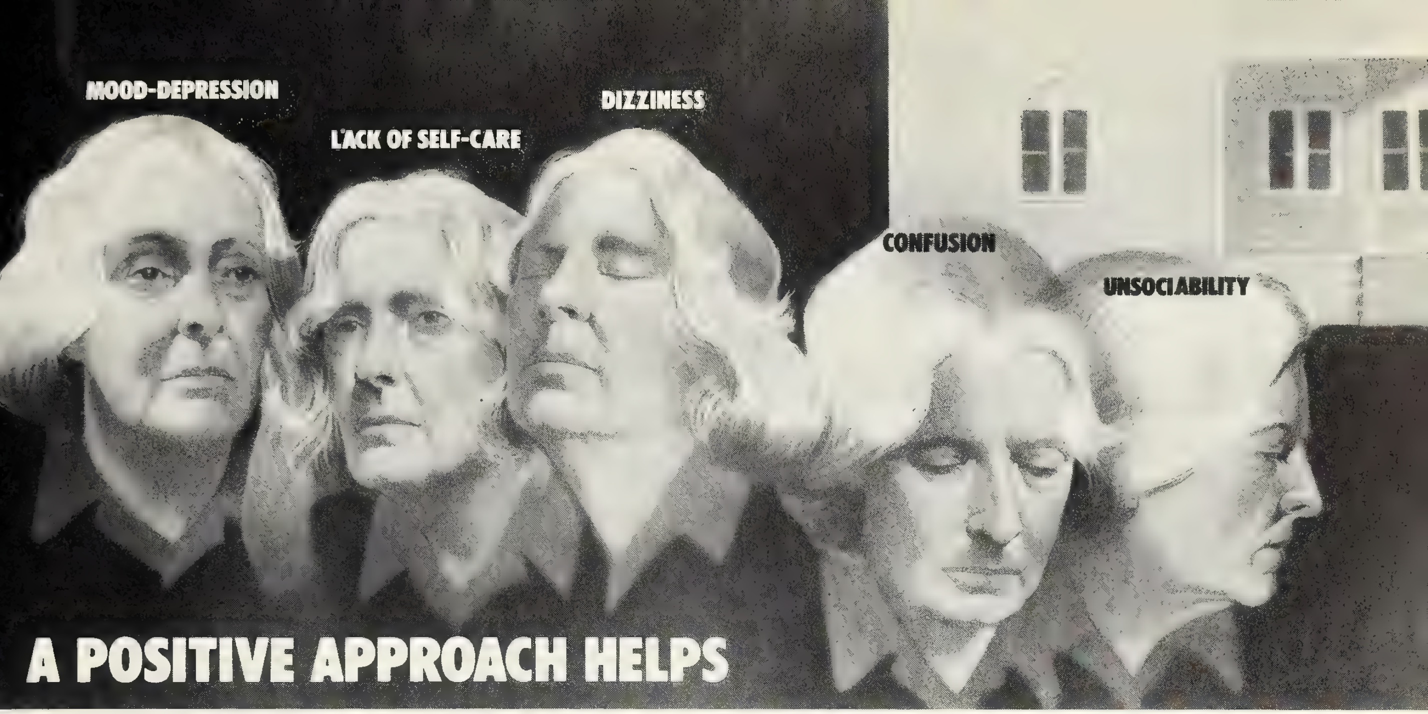
To the issue at hand. I find the proposal unacceptable. It fails to respond to our requests or to accomplish anything, in my opinion, that we were directed to achieve by the October 1977 special meeting of the House of Delegates, or of the May 1978 annual meeting. The issues precipitated in 1977 were:

1. The curtailment of long-term benefits under the psychiatric program in Major Medical.
2. The hearing aid program which required utilization of participating professionals and providers or no benefit would be available.
3. The vision care program which required a 20 percent co-pay or a 40 percent co-pay with defined upper limits on reimbursement, the co-pay being higher when service is obtained from a non-participating provider.
4. Regional differences.
5. Specialist non-specialist differences.
6. Automatic update.
7. Formula for inflation adjustments.
8. Service benefit.
9. Target limits on expenditures.
    a. Targets.
    b. Penalty for over-utilization.
    c. Reward for under-utilization.
    d. Participating/non-participating under-utilization.
    e. Participating/non-participating differentials.

Doctor Crandall has appropriately made the point that a win-lose situation is counter-productive, sets the stage for continuing controversy and makes another battle inevitable. A win-win situation leaves both parties satisfied and is a prerequisite for peaceful co-existence. He also has made the point that we must function in an ambience of mutual trust, consideration, respect, and confidence. Unfortunately, I don't see that on either side.

I have set up a summary of the play as I see it and provided a score card for interested physicians' use. Perhaps we can introduce an element of objectivity into our considerations and decide what our action ought to be and why. If you'd like a copy of summary and scorecard, please contact *Michigan Medicine* at MSMS headquarters.

The MSMS Council voted March 7 to poll members of MSMS on the proposed agreement Doctor Heideman speaks of above. In addition, the council recommended the House of Delegates not adopt the document as currently presented.



ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1-mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

An improvement
that's easy to swallow

- No waiting for tablets to dissolve under the tongue.
- Easier dose administration for increased patient compliance—less need for supervision.
- Human bioavailability demonstrated.

Indications: Selected symptoms in elderly patients, such as mood-depression, confusion, unsociability, dizziness, and lack of self-care, of unknown etiology.
Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
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The Blues: This is a time to rethink fundamentals

By John R. Ylvisaker, MD Pontiac

You are being asked by your elected leadership to provide your personal vote on probably the most crucial issue which affects the practice of medicine today and will affect the destiny of the practice of medicine for decades to come.

When you vote your opinion on the proposal as negotiated, you will *not* be voting on: *How you will be paid for services.*

You actually will be voting on: *"Who will control the freedoms previously inherent in the practice of medicine as it exists in our vanishing free enterprise system?"*

Doctor Ylvisaker is MSMS treasurer.

Be aware! The proposal merely "tinkers" with a reimbursement system which already has been patchworked to death and whose fundamentals are unacceptable.

As one of your leaders of more than a decade, as an officer of your society who has been deeply concerned with building the economic strength of your society to preserve its viability for the pursuit of its goals, I am compelled to urge you:

1) Do not support the proposal.

2) Indicate strongly your disavowal of the entire system of full service benefit reimbursement which:

— Has insidiously eroded the accountability, even the integrity, of the patient-doctor relationship.

— Has made cost containment almost impossible.

— Now threatens the freedom of patients to choose their physicians and the right of physicians to provide care in a free economy.

— Places control of the profession in the hands of third parties.

3) Join with me to insist that your Society vigorously and aggressively develop a new system of reimbursement which:

— Will be fair to subscribers and physicians.

— Will be cost efficient.

— Will maintain freedom of practice, humanitarianism and professional integrity.

A resolution will be introduced at the House of Delegates May meeting to outline the necessary plan of action for the development of a new system of interaction with third parties.

This is a time to rethink fundamental philosophies. This is a time for truth. Who controls the subsistence of a man controls the man.

Michigan's CME activities in Act III: Improvement

Richard W. Pomeroy, MD, Lansing, president of the Michigan Association for Medical Education, was a featured speaker at the recent AMA Conference on CME for State Medical Associations and Specialty Societies held in Chicago.

In outlining Michigan's CME efforts, Doctor Pomeroy told the attendees Michigan will "continue self analysis and improve policies and systems accordingly; our MSMS House of Delegetes has requested a continuous review of quality, relevancy, and cost for CME in Michigan.

"Also, we plan to develop more uniform survey methods; encourage more CME activities in smaller hospitals and continue to maintain contact with national CME organizations. 'Act I' had been program development; 'Act II' polished the existing program, and 'Act III' is improvement."

Doctor Pomeroy continued, "The Third Act is still on. How many acts there will be is unknown. The orchestra, the players, and the stage hands are now performing better for the audience, and they are finding that the audience, or the physicians themselves, are also strong participants.

"All of this hard work and effort by the physicians of Michigan is aimed toward improved medical care in Michigan by means of improved continuing medical education. Exact measurements of the results lie in the future and at the moment are most difficult, if not impossible, to actually evaluate."

Also addressing the assembly of CME'ers from across the nation was Robert Tupper, MD, Ann Arbor, who discussed the accreditation process in a state society.

(Editor's note: MSMS members are invited to send their "viewpoints" to Michigan Medicine about the mandatory CME law in Michigan and/or about the CME offerings and problems in Michigan. Send them to Managing Editor, Michigan Medicine, 120 West Saginaw, East Lansing, 48823.)

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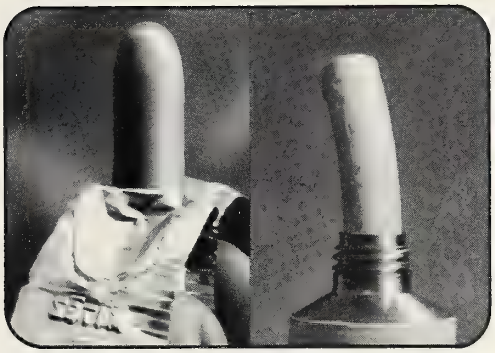

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

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Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

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Rebuttal to criticisms of stands on PAs' role

By Archie Bedell, MD
Detroit

In *Michigan Medicine*, October, 1978 William G. Birch Sr., MD, LLD, Largo, Fla. expressed much apprehension over a statement made by me in an earlier issue stressing principles of medical school training as distinct from those in the training of technicians. To quote my original paragraph, "There is great doubt in minds of many practitioners regarding role delineation between MDs and supervised, approved, certified physician assistants and other health extenders."

The use of the term technician resulted in a verbal barrage on my apparent insecurity or threatened stand by the presence of PAs in the medical world.

I am afraid that Doctor Birch failed to note the emphasis placed on "other health extenders." It is to this particular group, namely the nurse practitioners, and/or nurse health clinicians who are licensed under the Nursing Practice Act, and not under the Medical Practice Act that I was specifically referring.

Nurse practitioners

The nurse practitioner or nurse health clinician, in contrast to the PA, is not required by statute, act, and/or law to be under supervisory control of a physician.

Though Doctor Birch says "Doctors do not need to protect themselves from their helpers," I am afraid that if we are not careful, let alone concerned with other forms of health care extenders not under the supervisory control of physicians, we must ask what will happen to the quality of health care delivery, and to whom we leave such value judgments?

Physician assistants are certified; nurse practitioners, and/or nurse health clinicians, are licensed under their own act. The opportunity for independent practice by this latter group has been well substantiated. In New Jersey, nurse practitioners are not only licensed, but involved in independent practice, much like those in California.

The Medical Practice Act PA-185, Section 2 of Michigan clearly defines the "practice of medicine", or "to practice medicine" as "to diagnose, treat, prevent, cure or relieve a human disease, ailment, defect, complaint or other condition whether physical or mental, by attendance, or advice, or by a device, diagnostic test or other means, or to offer, undertake, attempt to do or hold oneself out as able to do any of these acts."

Doctor Birch need only to refer to the proposed rules of the Task Force on PAs, then the PA Advisory Committee of the Department of Licensing and Regulation of the State of Michigan to find they propose not to do definitive final diagnosis; this is to be left in the hands of the qualified practicing supervising physician. Therefore, they, too, desire to conform with the statutes of PA ACT 420.

Furthermore, the American Academy of Physician Assistants at its House of Delegates meeting in the spring of 1978, adopted the resolution, 78-48 as amended, "Resolved that a joint ad-hoc committee of the house of delegates and the board of directors be appointed to author a position paper, the posture of which shall be that the AAPA endorses the utilization of PAs only under responsible physician supervision, and in addition, that the AAPA reaffirm its position opposing independent practice by physician assistants, the paper to be submitted to the constituent chapters by December 31, 1978."

Most sympathetic

In Doctor Birch's desire to defend a laudable cause, he mistakenly attacked one who has been most sympathetic to the cause when he stated, "It is my fervent ongoing hope that those who fear encroachment by these new medically educated professionals, get out and get to know some of them, and thereby, put to rest many of their unfounded fears."

I can only assure Doctor Birch that the current president of the Michigan Academy of Physician Assistants, as well as another physician assistant, have been actively and happily employed by me for the last several years.

As with many articles in print, interpretation of the written word often occurs if emotions come into play. I also share many of Doctor Birch's concerns and empathize with his position on several issues. However, I truly feel that we must remain united as physicians, requiring supervision of our health care extenders including nurse practitioners and nurse health clinicians. They, like PAs, should conform to such regulation.

The welfare of the public rests in our hands, and we should, therefore, be allowed to guide all health care providers, based upon fact, not emotions, and recognize that the final diagnosis should always rest in the hands of the physician.

Doctor Bedell is a Detroit-area family physician.

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Mackinac Island regulars now served by FP residents

Since early January, the people of Mackinac Island have been receiving medical care from family practice residents placed on the island by the Michigan Academy of Family Physicians.

The residents serve two-week rotations under a new year-round plan endorsed in December by the MAFP board of directors. Coordinator is Harold E. "Pat" Crow, MD of Lansing.

"It's turned out to be a fascinating project," says Doctor Crow. "The people on the island are delighted with the residents." The residents have been teaching the islanders CPR, bandaging, splinting and other health care "they need to know to survive up there," Doctor Crow continues.

The physicians come from several Michigan family practice residency programs. Back-up is provided by the residents' own programs (by phone), and by Burns Clinic physicians in Petoskey. Islanders also are hospitalized at Burns Clinic, if needed.

Before the residents began serving in January, there had been no physicians for several months for the island's 600-800 permanent citizens. Previously, physicians served only sporadically on the island.

Gordon Willoughby, MD, Frankfort, academy president, calls the project "a positive demonstration of the ability of family practitioners to provide innovative and improved health care to underserved and isolated areas."

Michigan Medicine plans further coverage of the Mackinac Island project, including first-hand accounts by residents who have served.

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Tenuate Dospan®
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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*. Bone marrow depression, agranulocytosis, leukopenia *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

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References: **1**. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. **2**. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977

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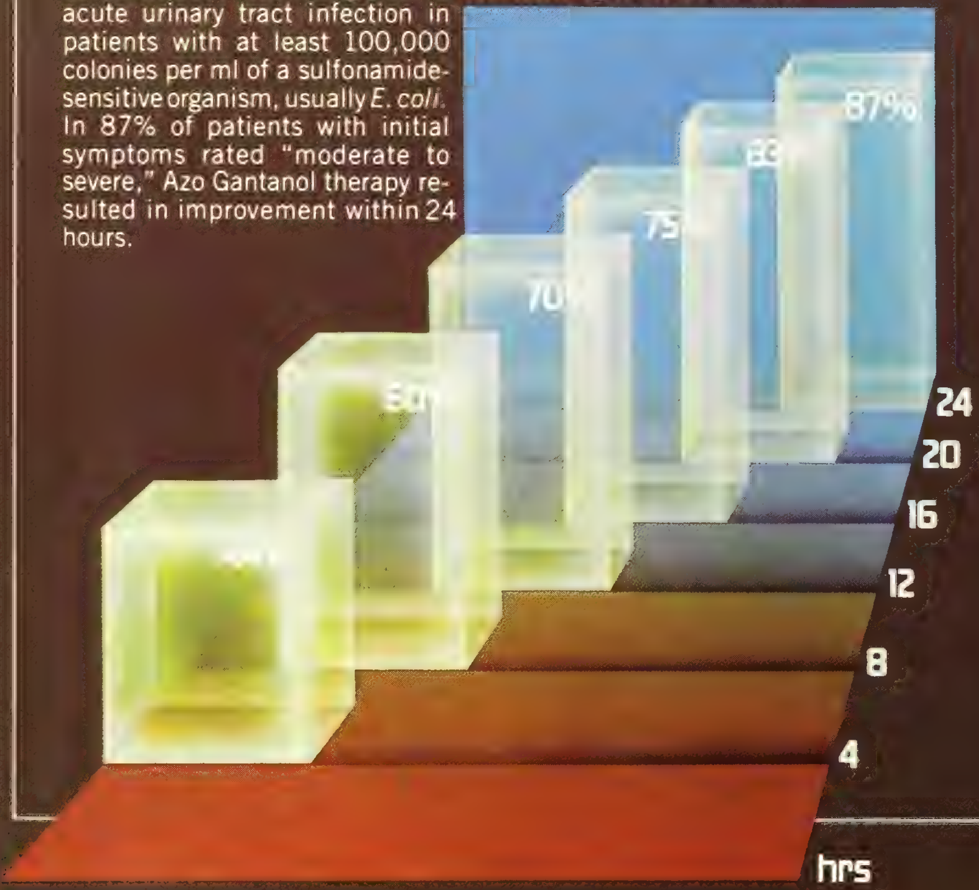

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the usefulness of antibacterials including sul
fonamides. Measure sulfonamide blood levels
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fonamide hypersensitivity; pregnancy at term
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tosis, aplastic anemia and other blood dyscra
have been reported and early clinical signs (s
throat, fever, pallor, purpura or jaundice) may
dicate serious blood disorders. Frequent CBC
urinalysis with microscopic examination are r
ommended during sulfonamide therapy.
Precautions: Use cautiously in patients with i
paired renal or hepatic function, severe aller
bronchial asthma; in glucose-6-phosphate
dehydrogenase-deficient individuals in whom
dose-related hemolysis may occur. Maintain
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Adverse Reactions: *Blood dyscrasias* (agran-
ulocytosis, aplastic anemia, thrombocytopeni
leukopenia, hemolytic anemia, purpura, hypo
thrombinemia and methemoglobinemia); *alle*
reactions (erythema multiforme, skin eruptio
Stevens-Johnson syndrome, epidermal necro
urticaria, serum sickness, pruritus, exfoliativ
dermatitis, anaphylactoid reactions, periorbi
edema, conjunctival and scleral injection, ph
sensitization, arthralgia and allergic myocard
G.I. reactions (nausea, emesis, abdominal pa
hepatitis, diarrhea, anorexia, pancreatitis an
stomatitis); *CNS reactions* (headache, periph
neuritis, mental depression, convulsions, ata
hallucinations, tinnitus, vertigo and insomnia
miscellaneous reactions (drug fever, chills, to
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Is your insurance keeping pace with today's economy?

By R. Timothy Hogan, CPBC
Ann Arbor

Inflation is undermining the insurance floor that most professionals have laid against a variety of risks that could have serious financial impact.

Insurance is particularly important to a physician whose income often is derived solely from a medical practice. Yet, the values of insurance policies purchased in the past are being eroded by the steady inflationary upswing. MDs should know that newer, more appropriate kinds of coverage are now available. My advice to a professional today is this:

— Reappraise necessary exposure to risks.

— Analyze your existing insurance coverages in light of current economic trends and your own financial requirements.

— Determine what types of insurance should be increased, decreased or dropped and other types substituted.

It has long been the philosophy of my firm that a professional should protect against the big risks but not necessarily all the small ones. It isn't possible or financially feasible to insure against every conceivable loss.

Assessing and updating insurance needs begins with taking a careful look at property, resources and earning power and figuring out the things that could go wrong. Let's look at some of these risks and briefly review the kinds of insurance available to counter them.

Risks to you personally

Death — It should be enough to stress that in today's economy it would require many more dollars to replace a doctor's income than it would have 10 or 20 years ago. Now is the time to determine if coverage is still adequate and appropriate.

Sickness and accidents — Likewise, an extended major accident or illness could cut deeply into the financial reserves of any professional. Some kind of hospital, surgical and major medical insurance protection is highly advisable.

Disability — A recent study shows the chances are one in three a doctor will suffer a long-term disability of at least three months sometime between age 36 and 65. Self-employed professionals rarely have "sick pay" to provide a financial cushion during such a disability period. Some disability policies also include coverage for rehabilitation services. One rule of thumb is the plan should provide approximately one-half of a doctor's pretax income, figuring in Social Security and any other possible benefits, for two to four months. Check your professional associations; many offer good disability insurance programs to members.

Risks to home, possessions, car

Fire — With home costs soaring, you may not be carrying enough fire insurance. Most fire insurance policies have a little-understood coinsurance provision requiring the policyholder to carry insurance limits equal to 80, 90 and sometimes 100 percent of the total market value of the house. Unless that obligation is met, you'll have to pay the difference between your actual coverage and what you should have carried. Thus, it is extremely important to keep fire insurance and related coverage in line with current home values.

Damage or loss to personal possessions — Again, it's quite likely coverages haven't kept pace with increasing values. Don't count on a homeowner's policy to fully cover things of special value — art collections, furs, silver, jewelry. You'll have to buy a special rider to fully insure them and you'll probably have to obtain an appraisal to document their value.

Car accidents — The possibility of huge liability for injury to others makes car insurance essential, if not mandatory. One insurance feature you should consider is the purchase of a personal umbrella policy — one that pays for any unusual claims or losses above the limits of basic auto coverage — up to $1 million or more. This umbrella liability policy can tie in with both homeowner's and auto insurance as well as with some office coverage. In today's climate of increasing costs for everything, it's a smart move to buy such protection. Another kind of coverage to consider is nonownership auto liability, which protects you in case an employee uses your car during working hours on job-related errands.

Risks to your practice

Professional liability suits — It's extremely unlikely that professional liability insurance will ever again be available at bargain rates. Despite its cost, only a small percentage of physicians and other health professionals have chosen not to carry it, since "going bare" puts a doctor's financial assets on the line.

Damage to office, its contents or to those who pass through it — Multiperil policies offer the framework for coverage in the property and liability areas of practice, and any number of special protective features can be incorporated. Again, as with your home, make sure your office fire and extended coverage are in line with current values. If you rent space, don't overlook providing coverage for any leasehold improvements you may have made, such as paneling, floor coverings and fixtures.

One area many doctors underinsure is office contents — equipment, furniture and supplies. Most policies provide for replacement cost, not for

(Continued on page 218)

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

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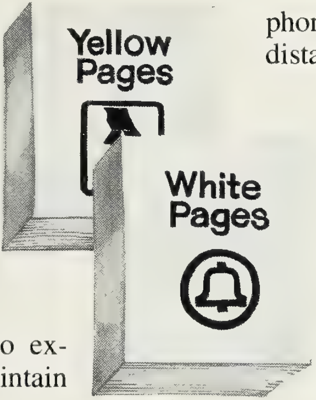

Your Remote Call Forwarding rate includes a listing in both the Yellow Pages. and White Pages.

SOLUTION:

The Michigan Bell Team has the answer for businesses that wish to deal with customers or field personnel in other locations. It's called Remote Call Forwarding. This service permits subscribers to obtain a local telephone number in one city and have calls to that number automatically forwarded via the telephone network to another number at any distant Michigan Bell location.

For example, a business in Detroit wishes to determine the market potential in Lansing. By subscribing to Remote Call Forwarding in Lansing, with a Lansing phone number, all calls received at that number are automatically forwarded and ring at the Detroit office.

Remote Call Forwarding includes a listing for your business in both the Michigan Bell Yellow Pages and White Pages of the directory of the distant city where the RCF service is provided, giving you local advertising and local identity. Customers can reach you directly, without going through an operator. Market potential in unknown areas can be tested without exorbitant cost.

Remote Call Forwarding gives businesses such as transportation, wholesaling, finance or retailing many of the conveniences of branch offices, with centralized control. The Michigan Bell Team, as part of the nationwide Bell System, will be happy to outline its advantages to you.

For more information on how RCF might help your business, call toll-free 1-800-482-3820.

**Whatever your business...
The system is the solution.**

Michigan Bell

Letters

"We hope the enclosed company check will help further your education programs"

Each year the management and employees of A. H. Robins Company seek to communicate their concern relevant to the health care in our country, and assure you of their continued support of your efforts on behalf of medicine.

Our concern centers upon the regulation that has been imposed by the Congress, state legislatures, and various federal agencies and, more importantly, the far-reaching implications of certain regulations which are being proposed. Not only are they being imposed on the pharmaceutical industry but upon medicine, pharmacy, hospitals and all other elements of our health care system. Experience indicates that the regulation of any segment constricts the prerogatives of the others. I urge you to be concerned and attentive to the issues that will affect our health delivery system in the future, and work toward change of those which have an adverse effect upon it now.

We have provided financial assistance to your organization, advertised in your journal, and supported several other activities such as our Physician Award program which honors doctors for community service. This year we again are offering our support. We hope the enclosed company check for $200 will be of help in furthering your professional or educational programs.

Please express our appreciation to the officers and members of your organization as they continue to serve the profession in Michigan.

E. Claiborne Robins, Jr.
A. H. Robins Company

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International Conference

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"Continued success . . . "

Thank you so much for the complimentary copy of February 1979 *Michigan Medicine*. Our auxiliary continues to serve the Grand Traverse-Leelanau-Benzie area in many ways. The recognition afforded us in the article by Anita Yannitelli was a pleasant surprise.

Continued success with the publication. It is always read with great interest in our household.

Pat (Mrs. Kenneth) Musson,
President
Grand Traverse Tricounty Auxiliary

BUSINESS*/continued*

actual purchase price of such things today. You may want to think about expanding your coverage by buying an extra-expense rider.

Liability protection for accidents and injuries on your office premises is essential, since doctors are prime candidates for suits stemming from such mishaps. Coverage of medical payments for anyone injured on your property also can be obtained.

Since many states specifically spell out an employer's financial responsibilities in the event an employee is hurt on the job, workmen's compensation insurance also is a sensible investment. These days many doctors also are buying life insurance, disability insurance and hospitalization benefits for employees as well.

Crime, theft, embezzlement — Medical offices are regularly burglarized by individuals looking for narcotics and money. Also, a professional sometimes discovers too late he has been cheated by a dishonest employee, occasionally for substantial amounts of money. Some thefts or losses can be covered under your multi-peril practice policy. Consider also buying a fidelity bond to insure against losses resulting from dishonesty.

Interruption of your practice — Finally, there's the risk that if you become ill, have an accident or are disabled for a period of time, you'll incur heavy financial losses. Even if you should become incapacitated, the cost of maintaining your office goes on. You can buy office overhead insurance, meshing the benefits that you would receive with your personal disability insurance discussed earlier, to help meet some of these costs. There are also some new types of insurance arrangements to help you recoup a good share of your income if you can't practice or can practice only part-time for awhile.

One last piece of advice: Put all your insurance into the hands of one broker. You don't want missing pieces in your protection. And a single insurance person is likely to give your program continuing attention over the years, alerting you when some policies should be altered to fit changing needs or the changing economic picture.

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Category I courses

***Michigan Medicine** each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: April 12, Conference on Medical Aspects of Sports. Location: Towsley Center, Ann Arbor. **Sponsor:** MSMS. **Contact:** Mert Scholten, MSMS, 517/337-1351. **Approved for:** 7 hours of Category I Credit.

Date: April 16-20, Family Practice Review. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Family physicians. **Cost:** $275. **Contact:** Towsley Center for CME. 313/764-2287. **Approved for:** 37 hours of Category I Credit.

Date: April 16-June 18, Pediatric Seminar IV. Location: St. John Hospital Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $200. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 20 hours of Category I Credit.

Date: April 19, 20, 1979, Michigan Chapter American College of Surgeons. Location: Ann Arbor, Rackham Building. **Sponsor:** University of Michigan Medical Center. **For:** Surgeons. **Cost:** No charge. **Contact:** John H. McLaughlin, MD, 604 N. Woodward, Birmingham, Michigan. **Approved for:** 12 hours of Category I Credit.

Date: April 20, "Cardiac Rehabilitation and Exercise Testing Symposium." Location: Borgess Hospital Auditorium, Kalamazoo. **Sponsors:** Cardiac Rehabilitation Center, Borgess Hospital; Southwestern Michigan Area Health Education Center; Michigan Heart Association, and American Academy of Family Physicians. **For:** All Interested Physicians. **Cost:** $50. **Contact:** Enrique Leguizamon, MD, Cardiac Rehabilitation Center, Borgess Hospital, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 7 hours of Category I Credit.

Date: April 22, 21st Annual Spring Clinic, "Gastroenterology." Location: Valley View — Shepherd. **Sponsor:** Central Michigan Community Hospital, Mt. Pleasant. **Co-Sponsor:** Gratiot Community Hospital, Alma. **Contact:** Frank D. Johnson, MD, Director, Continuing Medical Education, CMCH, 1221 S. Drive, Mt. Pleasant 48858, 773-7941; or Mary Jane Conkright, Medical Staff Secretary, 773-7941, Ext. 190 CMCH. **Approved for:** 8 hours of Category I Credit.

Date: April 23-27, Cardiology Tutorial Program. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital, Office of Continuing Education. **For:** General practitioners and internists. **Cost:** $300. **Contact:** Sidney Goldstein, MD, Div. of Cardiovascular Medicine, 313/876-2727. **Approved for:** 40 hours of Category I Credit.

Date: April 24, Continuing Pathology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $25. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 7 hours of Category I Credit.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakwood Hospital, Dearborn
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

Date: April 26-28, Eighth Annual Critical Care Symposium. Location: Wayne County Medical Society headquarters, 1010 Antietam, Detroit. **Sponsor:** Department of Surgery, Wayne State University School of Medicine, and Michigan Committee on Trauma, American College of Surgeons. **Cost:** $95. **Contact:** Robert F. Wilson, MD, Department of Surgery, Wayne State University School of Medicine, 540 E. Canfield, Detroit 48201. **Approved for:** 15 hours of Category I Credit.

Date: April 28, Decision Making in Difficult Cardiac Patients. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $70. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: April 30-May 2, Current Topics in Allergy and Clinical Immunology. Location: U-M, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, U-M. **Cost:** $180. **Contact:** Office of Continuing Education, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109, 313/764-2287. **Approved for:** 21½ hours of Category I Credit.

Date: May 2, "Practical Management of Seizures." Location: Borgess Hospital Auditorium, Kalamazoo. **Sponsor:** Neurology Department, Borgess Hospital. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All Interested Parties. **Cost:** $40. **Contact:** Charles L. Zeller, Jr., MD, Director Continuing Medical Education, Southwestern Michigan Area Health Education Center, 252 East Lovell Street, Room 364, Kalamazoo 49007, 616/383-6489. **Approved for:** 7 hours of Category I Credit.

Date: May 5, Spring Northern Michigan Perinatal Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Northern Michigan Hospitals, Inc., Petoskey. **For:** Pediatricians, obstetricians, family practitioners. **Cost:** $30. **Contact:** Rochelle Igrisan, RN, Perinatal Nurse-Educator, Northern Michigan Hospitals, Inc., Petoskey 49770, 616/374-7373 or 616/347-5000. **Approved for:** 6 hours of Category I Credit.

Date: May 7, 8, 9, Venereal Disease Symposium. Location: Park Place Hotel, Traverse City. **Sponsor:** American Social Health Association, Blue Cross/Blue Shield of Michigan, Michigan Department of Public Health. **Contact:** Michigan Dept. of Public Health, Venereal Disease Div., 3500 N. Logan, P.O. Box 30035, Lansing 48909. **Approved for:** 8 hours of Category I Credit.

Date: May 8, Human Values and Health Care. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical School. **Cost:** $50. **Contact:** Office of Continuing Education, University of Michigan Medical School, The Towsley Center, Ann Arbor 48109. **Approved for:** 7 hours of Category I Credit.

Date: May 10-11, Ophthalmology Conference. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: May 10-11, Heart Days. Location: Kalamazoo Center, Kalamazoo. **Sponsor:** Michigan Heart Association. **For:** Physicians, nurses, therapists and all allied health personnel. **Cost:** Physicians: $50 (two days) or $30 (one day). **Contact:** Michigan Heart Association, P.O. Box LV-160, Southfield 48076. **Approved for:** 10 hours of Category I Credit.

Wayne State University School of Medicine Alumni Association 111th Medical Alumni Reunion Day

Wednesday, May 9, 1979
Michigan Inn
Southfield, Michigan

REGISTRATION:
8:30 a.m.-9:30 a.m.

PROFESSIONAL SESSIONS:
9:30 a.m.-10:00 a.m.
"Noninvasive Cardiac Diagnosis"
10:00 a.m.-10:30 a.m.
"Cardiac Ultrasound"
10:30 a.m.-11:00 a.m.
"Nuclear Cardiology"
11:00 a.m.-11:30 a.m.
"Cardiac Catherization"

LUNCH:
11:45 a.m.-1:15 p.m.
(Includes student and distinguished alumni awards, annual business meeting)

AFTERNOON SESSIONS:
1:30 p.m.-2:00 p.m.
"Medical Treatment of Coronary Artery Disease"
2:00 p.m.-2:30 p.m.
"Surgical Treatment of Coronary Artery Disease"
2:30 p.m.-3:00 p.m.
"Patient's Viewpoint"

PANEL DISCUSSION:
3:00 p.m.-4:00 p.m.

RECEPTION:
6:00 p.m.

DINNER AND PRESENTATION OF GOLD AND SILVER ANNIVERSARY CERTIFICATES:
7:00 p.m.
(Dancing and entertainment will follow dinner)

5 hours of CME credit in Category I.
For further information call WSU School of Medicine (313) 577-1495

CATEGORY I/*continued*

Date: May 11, 12, Common E.N.T. Problems. Location: Radisson-Cadillac Hotel, 1114 Washington Blvd. at Michigan Ave., Detroit 48231, 313/256-8000. **Sponsor:** Wayne State University School of Medicine, Dept. of Otolaryngology. **For:** Primary care physicians. **Cost:** $120. **Contact:** Wayne State University School of Medicine, Div. of CME, 540 E. Canfield, 1206 Scott Hall, Detroit 48201, 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: May 12, Michigan Society of Pathologists May Seminar, "Mucosal Biopsy of the Gastrointestinal Tract." Location: Hurley Hospital, Flint. **Sponsor:** Mt. Carmel Mercy Hospital, Dept. of Pathology. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit, MI. **Approved for:** 3 hours of Category I Credit.

Date: May 14-18, Head and Neck Oncology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otorhinolaryngologists, surgeons. **Cost:** $500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: May 17, 18, Symposium on Glaucoma Surgery. Location: Detroit Plaza Hotel. **Sponsor:** Kresge Eye Institute and Dept. of Ophthalmology of Wayne State University. **Cost:** $150. **Contact:** Mr. Bud Prieur, CME, 313/577-1180 or Dong H. Shin, MD, PhD, program director, 313/577-1320. **Approved for:** 15 hours of Category I Credit.

Date: May 18, Infectious Diseases Symposium. Location: Grand Rapids. **Sponsor:** Butterworth Hospital, Grand Rapids. **Contact:** Butterworth Hospital Medical Education Office, 616/774-1835. **Approved for:** 7 hours of Category I Credit.

Date: May 21-25, Advances in Internal Medicine Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Internists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: May 21-25, Principles of Milieu Practice: Working with the Elderly in Treatment Settings. Location: Institute of Gerontology and School of Education, The University of Michigan/University of Michigan Medical School. **Sponsor:** U-M. **Cost:** $140. **Contact:** Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4102. **Approved for:** 30 hours of Category I Credit.

Date: May 23, Rheumatology Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: May 23, "Orthopaedic Problems For The Non-Orthopaedist." Location: Kalamazoo Hilton Inn. **Sponsor:** Orthopaedic Section, Bronson and Borgess Hospitals, Kalamazoo. **Co-Sponsor:** Southwestern Michigan Area Health Education Center, 252 East Lovell Street, Kalamazoo. **For:** All Interested Physicians. **Cost:** $40 Advance Registration. **Contact:** Charles L. Zeller, Jr., MD, director, Continuing Medical Education, Southwestern Michigan Area Health Education Center, 252 East Lovell Street, Room 364, Kalamazoo 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 24-26, Workshop in Advanced Cardiac Life Support. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $175. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 20 hours of Category I Credit.

Date: June 7-8, Blood Banking. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $90. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: June 7, 8, 9, Annual Keyport Trauma Symposium. Location: Otsego Ski Club, Gaylord. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons. **Cost:** $25. **Contact:** B. E. Henig, MD, 308 Michigan Ave., Grayling 49738, 517/348-6611. **Approved for:** 12 hours of Category I Credit.

Date: June 11-12, Issues in Hospice Care for the Elderly: A Forum. Location: U-M. **Sponsor:** Institute of Gerontology, The University of Michigan; The University of Michigan Medical School; and the United Way of Washtenaw County. **Cost:** $75. **Contact:** Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4102. **Approved for:** 11 hours of Category I Credit.

Date: June 17-23, Advanced Institute in Methods of Immunological Diagnosis. Location: Cranbrook Educational Community, Bloomfield Hills. **Sponsor:** World Health Organization Collaborating Laboratory for the Serology of Autoimmune Diseases at Wayne State University School of Medicine. **Cost:** $600. All inclusive. **Contact:** Noel R. Rose, MD, PhD, Dept. of Immunology and Microbiology, WSU School of Medicine, 540 E. Canfield, Detroit 48201. **Approved for:** 60 hours of Category I Credit.

Date: Aug. 10-12, ECG Interpretation and Arrhythmia Management. Location: Shanty Creek Hilton, Bellaire. **Sponsor:** International Medical Education Corporation. **Cost:** $202. **Contact:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. 800/525-8646 Toll free. **Approved for:** 15 hours of Category I Credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

SIG-MED offers help to Michigan physicians considering computers

Complete, functional, medical oriented computer system cost has approached the equivalent of an office assistant paid four or five dollars an hour and takes no sick days or vacation.

Interest by private practicing physicians in computer applications is growing as the prices of hardware decrease, software becomes available and paperwork escalates.

Attainable applications include a rational appointment system, all billing whether private or third party, extensive and complete accounting functions, classification and examination of your own clinical experience, recall notices, as well as the potential to access the extensive data banks maintained by various groups within US, i.e. Mumps type, Stanford, Index medicus and Lockheed.

It is proposed this growing interest by individual physicians and small groups be channeled via some organizational effort so as to capture maximum physician input in system design and cost.

A computer user (and potential user) group is being formed under the auspices of the Southeastern Michigan Computer Organization (SEMCO) called Special Interest Group — Medicine (SIG-MED). SEMCO dues are $10 per year. Financing of SIG-MED activities is left to members to determine by their program requirements.

Any physician starting to investigate the feasibility of computers in office practice should find this an excellent place to start.

For further information contact Marion McCall, MD, 18242 Fairfield, Detroit, 48221. Phone 313/863-0122 evenings. SEMCO dues checks should be drawn to "S.E.M.C.O." and should show on the back name, address for SEMCO mailings, a phone number for both day and evening calls and the notation "SIG-MED."

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY???

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- ☑ Waiver of Premium
- ☑ Survivors' Benefits
- ☑ Professional liability premiums are a covered expense
- ☑ Premiums deductible as a business expense
- ☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Deaths

James H. Bultema, MD
Muskegon

James H. Bultema, MD, Muskegon, died Jan. 27 at the age of 57. A surgeon, Doctor Bultema was a graduate of Northwestern University, Illinois. He was affiliated with Hackley and Mercy hospitals, Muskegon, and served in the Navy and Army.

William F. Jackson, MD
Rogers City

William F. Jackson, MD, Rogers City, died Jan. 16. He was 65. Doctor Jackson graduated from the University of Michigan Medical School. He was affiliated with Alpena General Hospital and Rogers City Community Hospital. He was a past president of Alpena-Alcona-Presque Isle County Medical Society and was a charter member of the American Academy of General Practitioners, Detroit Chapter.

Owen S. Hendren, MD
Tucson, AZ

Owen S. Hendren, MD, formerly of Oakland County, died Nov. 29 at the age of 79. A dermatologist, Doctor Hendren graduated from the College of Medicine, University of Tennessee. He was affiliated with St. Joseph and Pontiac General hospitals, Pontiac, and Detroit Receiving Hospital. He was a past treasurer of the Oakland County Medical Society, and was a member of the Detroit Dermatological Society and the American Academy of Dermatology and Syphilology.

Herbert S. Kallet, MD
Southfield

Herbert I. Kallet, MD, Southfield, died Jan. 19 at the age of 83. Doctor Kallet was a graduate of Syracuse University College of Medicine, New York. He was chief of proctology at Harper Hospital and was on the staffs of Sinai, Crittendon and Beaumont hospitals. Doctor Kallet was a former associate professor and department of proctology chairman at Wayne State University. He served as vice-president of the American Proctology Association. He was a diplomat of the American Board of Surgeons. He also was a member of the Michigan Proctologic Society, and a fellow of the American College of Surgeons.

Andrew G. Lasichak, MD
Detroit

Andrew G. Lasichak, MD, Detroit, died Nov. 20 at the age of 65. Doctor Lasichak, a surgeon, was a graduate of Jefferson Medical College, Pennsylvania. He was affiliated with St. Francis Hospital, Hamtramck; Mt. Carmel Hospital, Detroit; and St. Mary Hospital, Livonia. He was a member of the Detroit Physiological Society and the American Federation of Clinical Research.

Sydney N. Lyttle, MD
Flint

Sydney N. Lyttle, MD, Flint, died Jan. 29 at the age of 60. A graduate of the University of Michigan Medical School, Doctor Lyttle was affiliated with Hurley, St. Joseph and McLaren hospitals, Flint. He was a fellow of the American College of Surgeons and a member of the AAST.

Grace M. Perdue, MD
Pompano Beach, FL

Grace M. Perdue, MD, formerly of Detroit, died Jan. 28 at the age of 78. Doctor Perdue graduated from the University of Toronto. An obstetrician and gynecologist, she was a staff member at Hutzel Hospital where she directed the outpatient clinic. She was a member of the Academy of Obstetrics and Gynecology and a fellow in the Academy of Obstetrical-Gynecological Medicine. She was also past president of the Blackwell Medical Society.

The MSMS Bureau of Economics wants you to know:

Purchasing power for the average American family will be reduced by $786 this year because of actions by the last Congress.

That's the basic finding of an analysis by the National Chamber Forecast and Survey Center, which reviewed congressional decisions on key economic issues in 1977 and 1978.

Chamber officials noted in announcing findings of the survey that "more and more Americans are coming to understand the awesome economic story of the 1970s: 'Inflation is produced in Washington.' "

Here are the anticipated effects of various congressional actions of the past two years, by the percentage increase in prices and by the amount of lost purchasing power per average family:

- Minimum wage increases — 2 percent; $554.
- Higher Social Security taxes — 0.2 percent; $40.
- Farm supports — 0.5 percent; $148.
- Energy policy — 0.2 percent; $17.
- Air-quality controls — 0.1 percent; $27.
- Gross impact — 3 percent; $786.

–from the Washington Report, semi-monthly newsletter of the U.S. Chamber of Commerce.

Doctor Vasu appointed

C. Mark Vasu, MD, Grand Rapids, has been appointed to the statewide Emergency Medical Services Advisory Council by Governor William Milliken. As reported earlier, **John Wiegenstein, MD,** of Lansing, also serves on the Council.

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The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

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FAMILY PHYSICIANS — SOUTHEAST — Alabama, Florida, Georgia, West Virginia. Excellent private practice opportunities near hospitals with attractive monthly guarantee and free office space. Warm climate, good schools and outdoor recreation. Send curriculum vitae in confidence to: Mr. William Anderson, Search Director, 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Georgia 30338.

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ANESTHESIOLOGY RESIDENT TRAINING PROGRAM seeks qualified Michigan applicants. Experience in general practice or primary care preferred. Inquire: Lucien E. Morris, MD, Dept. of Anesthesia, Medical College of Ohio, Caller Service #10008, Toledo, OH 43699.

STAFF PHYSICIANS, East Lansing, Ingham County — Michigan State University student health service is currently recruiting for full-time staff physicians. The University has a student enrollment in excess of 40,000 and is located in a metropolitan area of 250,000. Athletic and cultural programs are available to staff. Olin Health Center is located on campus and provides facilities for students in need of medical, surgical or psychiatric care. Facilities include a large outpatient program, in addition to a separate outpatient gynecological clinic, limited inpatient capability and completely outfitted private office suites. Physicians must be licensed to practice in Michigan or immediately capable of obtaining such a license. Professional work is in the area of general practice with surgery confined to limits of the physician's experience. No pediatric, geriatric or obstetrical service. Physicians rotate night and weekend duty. Fringe benefits include TIAA CREF retirement program, paid hospital and malpractice insurance, one month paid vacation and liberal sick leave benefits. Starting salary negotiable. Contact: Michigan State University, Personnel Office, 110 Nisbet Building, East Lansing, MI 48824. EOE.

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POSITIONS AVAILABLE — With offices in Lansing, Oak Park and Traverse City, there are openings for physicians board certified or qualified as internists, family physicians or psychiatrists working with the Disability Determination Service under the Social Security Administration. Salary currently between forty-seven and fifty-eight thousand per year, plus 23% fringe benefits, including life, accident, long term disability, dental, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years service. Liability insurance not necessary. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7830. In Michigan, call toll free 1-800-292-2710.

Miscellaneous

ESTABLISHED MEDICAL FACILITY available July 1. 1200 sq. ft. in Waterford, Drayton Plains area. Contact B. J. Jacks, DDS, 6021 Williams Lake Road, Drayton Plains, MI 48020, 313/623-7722.

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FOR SALE: General practitioner's black leather bag with otoscope and ophthalmoscope, baumareometer, stethoscope, pill case and sundry items. All in excellent condition. Contact: John Berghorst, MD, 89 S. LaVista Blvd., Battle Creek, MI 49015. Phone 616/963-9565.

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resident's page

We all pay for health care; we must decide together forms it takes

Louis E. Heideman, MD
MSMS president

It's an old cliche that he who pays the piper calls the tune . . . but who is the payor when it comes to health care? Many claim this privilege and therefore demand the right to call the tune.

The reality is that each and every one of us pays the piper, albeit at times through other parties, so that it would seem the right of each of us to decide what we want out of health care. This obviously has certain implications for us as physicians in determining what our proper actions are.

Union, employer, legislature

The unions claim they bargain for certain health insurance by authority of their members, giving up other goals in order to pay for health care. Therefore, they claim, they can call the tune, which includes a national health service with physicians working on a salary under conditions laid down by "consumers." "Consumer" here is equivalent to the most powerful union. The reality is that it is still their members' resources that are being bargained with, at times with the consent and knowledge of the members, at times with the union assuming the role of big brother and telling the members what is good for them.

The employer claims the right to call the tune by virtue of paying the bill. But the employer is paying with employee dollars on the one hand, on the other hand these dollars are derived from the purchasers of the manufactured item, the only source of revenue the employer has. Here the employer is a transfer agent and not an independent contractor.

A variety of legislative bodies and administrative agencies claim the right to call the tune by virtue of the fact that over 40 percent of health care costs are paid for today through governmental coffers either in the guise of social security contributions or from general revenue raised by a variety of taxes. Again, the government is acting as the agent of each and every resident of the United States, having no source of revenue other than what we agree to pay in taxes. We have delegated to our elected legislators the authority to raise these taxes. We have not delegated the right to make personal decisions for us.

And then there is the infestation of professional consumer advocates who profess to speak for the consumer, who profess to know more about consumer wants than anyone else and to speak with their authority. I have seen some such characters operate and they tell the ever-changing consumer constituency what is good for them and then pretend to speak with the authority of their ephemeral constituency. There are interested and committed individuals who are knowledgeable and effective, but they are rare among the so-called consumer spokespeople.

Health care economics

The cliche today is that the basic economic rules do not apply to health care because the professional can control demand and neither the patient nor the professional has any motivation to make choices with third parties of a variety of genres being the agents for paying the tab.

A good part of this reflects a lack of awareness of what is going on in health care, and of the fact that each of the using parties does make a variety of choices.

There are some distortions and uneconomic actions, but these cannot ever be controlled until we go back to some mechanism of direct involvement of the patient and the physician in the financial area. A concommittant is to re-educate our population as to what constitutes good health care, with a decrease in demand and the evolution of more realistic expectations of their health care as results.

We must, then, be prepared to look to our patients for the payment of fees; we must review and evaluate the services we are providing; we must learn to talk economics with our patients and arrive at joint decisions as to what is appropriate and what is excessive. But most of us have been doing this all along in spite of the stereotype projected by those who would change our entire health care system.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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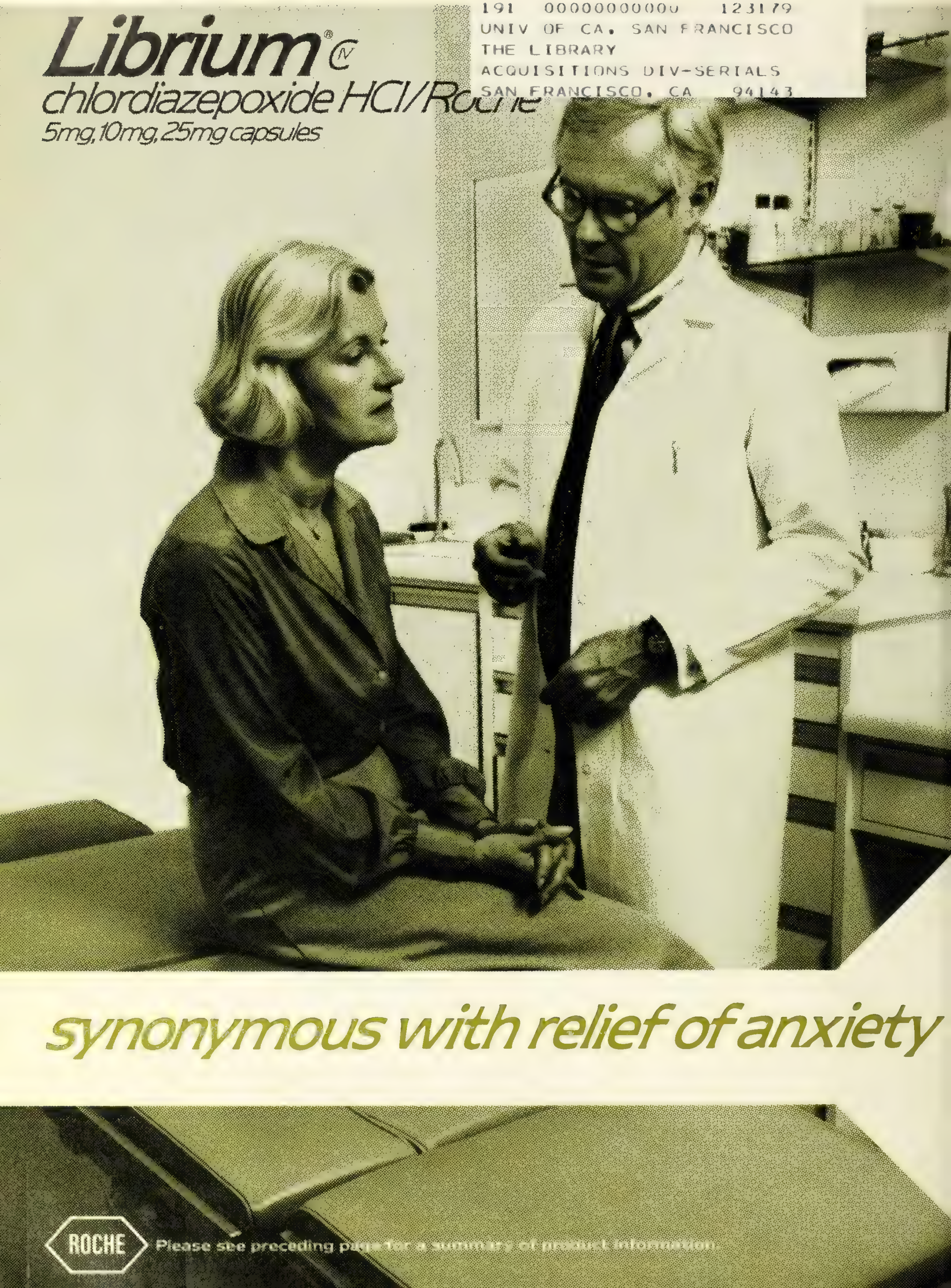

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synonymous with relief of anxiety

ROCHE Please see preceding page for a summary of product information.

ATTENTION ALL MSMS MEMBERS!! Help in keeping track of CME credits earned is available with this special issue of Medigram. The inside four pages of this newsletter are a file folder designed to help you record credit earned and store documentation of your attendance at CME meetings. In addition, commonly asked questions are answered on the first page of the folder to help physicians better understand the requirements for relicensure. Please remove this folder and store it in your files for regular use.

PSULES

HE WAYNE COUNTY MEDICAL SOCIETY
s a new set of bylaws which will
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MSMS will serve until June 1980,
en annual meetings will be held.

* * *

NT TO HELP introduce a young med-
al student to the practice of
dicine and to hospital care? Hos-
tals and clinics interested in
sting pre-sophomore medical stu-
nts this coming summer may write
Herbert Auer, Michigan Health
uncil, Box 1010, East Lansing,
823.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 12 APRIL 23, 1979

DEC 14 1979

FTC continues investigation of MSMS

It would appear the Federal Trade Commission, in its investigation of MSMS, plans to take action that would prohibit MSMS from having any input into the health care plans of all third party payors, particularly Blue Cross/Blue Shield of Michigan. This is the most recent development in an FTC investigation underway since November to determine whether MSMS has attempted to control or participate in control of BCBSM. All MSMS councilors have been notified of this FTC development, and MSMS legal counsel now is talking with FTC lawyers in an attempt to insure appropriate physician input in the development of health care plans.

Michigan's John J. Coury, MD, seeks re-election as AMA trustee

Michigan's AMA Board of Trustee member John J. Coury, MD, will seek re-election at the AMA House of Delegates July 22-26 annual meeting in Chicago. Doctor Coury was first elected in 1976 and has served as AMA Board Finance Committee chairman since 1978. He also serves on two board review committees and is active on the AMA councils on Long Range Planning and Development, Constitution and Bylaws and the AMA Education and Research Foundation. He is vice president of the latter.

Doctor Coury is past president of MSMS, served on the MSMS Council and was an AMA delegate several years before being elected as a trustee. He has been a practicing surgeon in Port Huron since 1951.

RETURN YOUR BALLOTS BY APRIL 28: That is the deadline for completion and return of ballots on the Michigan physicians Blue Cross/Blue Shield of Michigan proposal. Please contact William Madigan at MSMS headquarters with any questions.

Articles by Doctor Heideman and Doctor Ylvisaker appearing on this and the facing page also appeared on pages 206 and 208 of the April issue of Michigan Medicine.

Blues using money to fragment medical profession

By Louis E. Heideman, MD
MSMS president

It is unfortunate that we are faced with a divisive issue at a time when unity within the medical profession is essential. It also is unfortunate that that issue, ultimately, is money.

There is nothing wrong with money, or the expectation of a fair payment for an adequate service. But when it becomes the primary concern and focus for decision-making over our commitment to the provision of health care in a manner and under terms acceptable to our patients, our cause is lost.

As I look at our present situation, money is being utilized by outside sources in an attempt to fragment our profession, rendering it impotent and ineffective.

Efforts to control

The modification of the psychiatry programs, the hearing aid program, and the eye glass program, can be easily construed as efforts to pick off and control relatively small components of our profession.

The proposals to change payment mechanisms for the radiologists, pathologists, and anaesthesiologists in hospital practice are of the same genre. They originate from a single source, are presented in two forums — BCBSM and the Statewide Health Coordinating Council and again are aimed at small segments of our profession which have special problems and susceptibilities and impose the ultimate goal — salaried practice for all physicians.

The radiologists feel so threatened, so insecure, and abandoned by the rest of the profession that they have levied a special assessment. This is being utilized to obtain legal counsel and to obtain independent legislative lobbying support, the latter at an expenditure of $25,000 a year. The unhappy reality is that this has the potential of our unknowingly working at cross purposes, with the loss of their cause and the destruction of medicine.

We have been in conflict with Blue Cross and Blue Shield (now BCBSM) for many years over a variety of issues with generally increasing ill-will.

We have forgotten why these organizations came into existence, have not consistently recognized their legitimate needs (as they haven't recognized ours) and have not looked at the alternatives should BCBCM disappear. The most likely alternative, in my opinion, is a state or federally operated substitute. The Blues came into existence to avoid this. Is the alternative to the Blues any more acceptable now that it was in 1939?

Agreement unacceptable

To the issue at hand. I find the proposed agreement unacceptable. It fails to respond to our requests or to accomplish anything, in my opinion, that we were directed to achieve by the October 1977 special meeting of the House of Delegates, or of the May 1978 annual meeting. The issues precipitated in 1977 were:

1. The curtailment of long-term benefits under the psychiatric program in Major Medical.
2. The hearing aid program which required utilization of participating professionals and providers or no benefit would be available.
3. The vision care program which required a 20 percent co-pay or a 40 percent co-pay with defined upper limits on reimbursement, the co-pay being higher when service is obtained from a non-participating provider.
4. Regional differences.
5. Specialist non-specialist differences.
6. Automatic update.
7. Formula for inflation adjustments.
8. Service benefit.
9. Target limits on expenditures.
    a. Targets.
    b. Penalty for over-utilization.
    c. Reward for under-utilization.
    d. Participating/non-participating under-utilization.
    e. Participating/non-participating differentials.

Doctor Crandall has appropriately made the point that a win-lose situation is counter-productive, sets the stage for continuing controversy and makes another battle inevitable. A win-win situation leaves both parties satisfied and is a prerequisite for peaceful co-existence. He also has made the point that we must function in an ambience of mutual trust, consideration, respect, and confidence. Unfortunately, I don't see that on either side and I don't see the proposed agreement as moving us in the desired direction.

I have set up a summary of the play as I see it and provided a score card for interested physicians' use. Perhaps we can introduce an element of objectivity into our considerations and decide what our action ought to be and why. If you'd like a copy of summary and scorecard, please contact *Michigan Medicine* at MSMS headquarters.

The MSMS Council voted March 7 to poll members of MSMS on the proposed agreement Doctor Heideman speaks of above. In addition, the council recommended the House of Delegates not adopt the document as currently presented.

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MEDICAL SOCIETY
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EAST LANSING, MICHIGAN 48823

Detach and Retain as a File Folder

MSMS, in cooperation with the Michigan Board of Medicine, developed this Medigram section to help physicians to understand the new CME rules and to keep their records of attendance.

Has the reporting of CME rules compliance changed?	Yes. Instead of reporting on a separate card, you will certify compliance by signing the CME section of your re-registration card.
What does this change mean?	The Board of Medicine will be relying less on reports and more on audits of physicians' records to enforce compliance.
How important is the keeping of records on CME activities?	Failure to provide such evidence shall be deemed to establish a rebuttal presumption that the licensee made a false or fraudulent statement in applying for a license.
Who is responsible for keeping records on my CME activities?	You. As with IRS data, it is your responsibility to keep your records. Sponsoring institutions or organizations keep records, but these are only to substantiate your claims of participation.
What kind of evidence will be sufficient for the auditors?	Certificates of completion, receipts, cancelled checks--the same type of proofs asked by the Internal Revenue Service.
How long must records be kept?	Four years.
What is the CME year?	January 2-December 31.
Results of a November specialty board exam came in January--do I get credit in 1978 or 1979?	1979. Credit is for passing and recorded for the year in which you are so advised.
Can I count time on a hospital's Patient Care Committee as CME?	Yes, hour for hour credit in Category 5 up to 18 hours in three years.
Does having a medical student on a clinical preceptorship with me for a month qualify as CME?	Probably in Category 3, but check details with the Board of Medicine for a definite answer and the number of hours.

Re-registration application cards mailed to physicians will have a CME requirements compliance section similar to this:

CERTIFICATION OF COMPLIANCE

I hereby certify that I have earned 150 hours of Continuing Medical Education in the preceding 3 years (1977-78-79), including a minimum of 75 hours in Category I; or 100 hours of Continuing Medical Education in the preceding 2 years if originally licensed in Michigan in 1978, or 50 hours of Continuing Medical Education in the past year if originally licensed in Michigan in 1979. I understand that it is my responsibility to maintain evidence of my compliance with the CME requirements, that this evidence must be kept for a period of 4 years and that I am subject to an audit of all such evidence. I acknowledge that the Michigan Board of Medicine considers this a part of my application for renewal of medical licensure.

____________________ (signature) __________ (date)

Retain this folder to record activities and keep CME programs, notes, receipts

Category 1

Activities with accredited sponsorship;
tutorial experience; medical ethics;
specialty board certification/recertification

1977 cr.hrs.___

1978 cr.hrs.___

Minimum credit hours (clock hours) in three years: 75; maximum, 150.

ACTIVITY ____________________ Date _____ cr.hrs.____/___
Sponsor or tutor ____________________ Location __________

ACTIVITY ____________________ Date _____ cr.hrs.____/___
Sponsor or tutor ____________________ Location __________

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Sponsor or tutor ____________________ Location __________

ACTIVITY ____________________ Date _____ cr.hrs.____/___
Sponsoor or tutor ____________________ Location __________

Category 2

Activities with nonaccredited sponsorship — 1977 cr.hrs._____

Maximum credit hours (clock hours) in three years: 36. — 1978 cr.hrs._____

ACTIVITY ____________________ Date ______ cr.hrs._____/_____

Sponsor ____________________ Location __________

ACTIVITY ____________________ Date ______ cr.hrs._____/_____

Sponsor ____________________ Location __________

ACTIVITY ____________________ Date ______ cr.hrs._____/_____

Sponsor ____________________ Location __________

Category 3

Teaching physicians or allied health services — 1977 cr.hrs._____

Maximum credit hours (two per clock hour) in three years: 48 — 1978 cr.hrs._____

ACTIVITY ________________ Audience __________ cr.hrs._____/_____

Sponsor ________________ Location __________ Date ______

ACTIVITY ________________ Audience __________ cr.hrs._____/_____

Sponsor ________________ Location __________ Date ______

ACTIVITY ________________ Audience __________ cr.hrs._____/_____

Sponsor ________________ Location __________ Date ______

Category 4

Books, papers, publications, and exhibits — 1977 cr.hrs._____

Maximum credit hours (clock hours) in three years: 48 — 1978 cr.hrs._____

ACTIVITY ____________________ Date ______ cr.hrs._____/_____

Event and place
Publication or publisher ____________________

ACTIVITY ____________________ Date ______ cr.hrs._____/_____

Event and place
Publication or publisher ____________________

ACTIVITY ____________________ Date ______ cr.hrs._____/_____

Event and place
Publication or publisher ____________________

Category 5

Nonsupervised education

1977 cr.hrs._____

Maximum credit hours (clock hours) in three years: 36.

1978 cr.hrs._____

Self-assessment (Maximum credit hours: 18)
Self-instruction (Maximum credit hours: 18)
Quality care or utilization review (Maximum credit hours: 18)

ACTIVITY ____ cr.hrs._____/_____

ACTIVITY ____ cr.hrs._____/_____

ACTIVITY ____ cr.hrs._____/_____

Category 6

Full-time participation in graduate training program of at least five full months

1977 cr.hrs._____

1978 cr.hrs._____

Maximum credit hours: 50 per year.

PROGRAM SITE ____

Program dates _________

CONTINUING MEDICAL EDUCATION RULES INFORMATION

The Michigan Board of Medicine will mail complete copies of the CME rules to Michigan licensees. All requests for additional information should be sent to:

Michigan Board of Medicine
905 Southland
P.O. Box 30018
Lansing, Michigan 48909

The board may deny a request for approval of activities for CME credit whenever it appears that the request fails to demonstrate compliance with the legislative intent to further educate licensees on subjects related to the practice of medicine.

SUMMARY OF CME CREDIT

	1977	1978	1979
Category 1	_____	_____	_____
Category 2	_____	_____	_____
Category 3	_____	_____	_____
Category 4	_____	_____	_____
Category 5	_____	_____	_____
Category 6	_____	_____	_____
TOTALS	_____	_____	_____

The Blues: This is a time to rethink fundamentals

By John R. Ylvisaker, MD
Pontiac

You are being asked by your elected leadership to provide your personal vote on probably the most crucial issue which affects the practice of medicine today and will affect the destiny of the practice of medicine for decades to come.

When you vote your opinion on the proposal as negotiated, you will *not* be voting on: *How you will be paid for services.*

You actually will be voting on: *"Who will control the freedoms previously inherent in the practice of medicine as it exists in our vanishing free enterprise system?"*

Doctor Ylvisaker is MSMS treasurer.

Be aware! The proposal merely "tinkers" with a reimbursement system which already has been patchworked to death and whose fundamentals are unacceptable.

As one of your leaders of more than a decade, as an officer of your society who has been deeply concerned with building the economic strength of your society to preserve its viability for the pursuit of its goals, I am compelled to urge you:

1) Do not support the proposal.

2) Indicate strongly your disavowal of the entire system of full service benefit reimbursement which:

— Has insidiously eroded the accountability, even the integrity, of the patient-doctor relationship.

— Has made cost containment almost impossible.

— Now threatens the freedom of patients to choose their physicians and the right of physicians to provide care in a free economy.

— Places control of the profession in the hands of third parties.

3) Join with me to insist that your Society vigorously and aggressively develop a new system of reimbursement which:

— Will be fair to subscribers and physicians.

— Will be cost efficient.

— Will maintain freedom of practice, humanitarianism and professional integrity.

A resolution will be introduced at the House of Delegates May meeting to outline the necessary plan of action for the development of a new system of interaction with third parties.

This is a time to rethink fundamental philosophies. This is a time for truth. Who controls the subsistence of a man controls the man.

Nine physicians appointed to arbitrator selector panels

Five members and four alternates have been named by the Michigan insurance commissioner to serve on the Arbitration Selection Subcommittee of the commissioner's Arbitration Advisory Committee. These nine MDs will review and select physicians to serve on panels for each medical malpractice case which follows the arbitration system for settlement. This is the third year panel selectors have been appointed since the Michigan medical arbitration system was initiated in 1975.

The five Arbitration Selection Subcommittee members are Robert W. Black, MD, Detroit; Raymond M. Engelman, MD, Flint; Richard O. Kraft, MD Ann Arbor; Gerald H. Mandell, MD, Detroit, and W. Peter McCabe, MD, Grosse Pointe Woods. Alternates are : Clayton E. Hurd, MD, Fenton; Lorraine A. Sievers, MD, Detroit; Donald N. Sweeny Jr., MD, Detroit, and Leonard H. Wolin, MD, Ann Arbor. Doctors Black, Kraft, Mandell, McCabe and Sweeny are reappointed, while the remaining are new. In addition, attorney, hospital administrator, consumer and osteopathic physician panel selectors have been appointed.

CAPSULES/Continued

MSMS's PHYSICIAN SERVICE GROUP, INC. will offer a Personal and Practice Financial Planning Seminar June 13, 14, and 15 for physicians and spouses. This one-day seminar will be offered in Lansing on June 13, Southfield on June 14 and Detroit on June 15.

The workshop will be staffed by Practice Productivity, Inc., of Atlanta and will give physicians and their spouses advice on financial planning for their practices and personal lives. Please contact John Anthony at MSMS with any questions: 517/337-1351.

CAPSULES/continued

IT'S FALLACIOUS TO ASSUME that all of the property you now have will be available for your family when you are gone. Physician Service Group, Inc. reminds you that estate and inheritance taxes and other estate costs are certain to eat up a sizeable portion of your property. It is very important that you face this situation realistically.

For efficient, experienced estate planning, call or write: Robert T. Stanziano, Director of Financial Services, MSMS/Physician Service Group, Inc., P.O. Box 950, East Lansing, MI 48823. 517/337-1351.

* * *

MSMS DUES WERE AMONG the considerations when the MSMS House of Delegates' Ways and Means Committee met April 19 in advance of the annual House meeting May 4-6 in Kalamazoo. The committee's recommendations will be included in its report to the MSMS House of Delegates.

* * *

THE STOCKWELL BUILDING addition to the MSMS headquarters is nearing completion. The MSMS Physician Service Group, Inc. and the Michigan Physicians Mutual Liability Co. plan to complete their move into the building by the end of May.

MSMS committee seeks MDs' comments on EMS categorization criteria

MSMS is seeking comments from physicians regarding the EMS Categorization Criteria. Comments will be transmitted to an MSMS ad hoc committee on EMS Categorization Criteria. The ad hoc committee will work with the statewide EMS Advisory Council in reviewing the categorization criteria as promulgated by the Michigan Department of Public Health. When completed, the EMS categorization criteria will be the basis for a program of mandatory categorization of emergency rooms. Copies of the EMS categorization criteria are available from the Michigan Department of Public Health at (517) 373-1406. Comments should be submitted no later than May 15 to MSMS, Physician/HSA Support Center, P. O. Box 950, 120 W. Saginaw, East Lansing, Michigan 48823.

Seminar set for MSMS members on office communication systems

A seminar on new physician's office communications developments is being offered at several locations in the Detroit area the first week in May. The seminar is designed especially for MSMS members by John H. Anthony, General Manager, MSMS Physician Service Group, Inc., and the Michigan Bell System. "Today, many outdated office management systems seem to linger in doctor's offices," says Mr. Anthony. "Streamlined communications systems are one key to solving doctors' office management problems. New communications systems and methods can help you provide the quality health care you want for your patients and the efficient practice you want for yourself." Seminar locations, dates and times may be obtaine by calling the Michigan Bell toll-free number: 1-800-482-3829.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS
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VOL. 78, NO. 13 MAY 14, 1979

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MAY [illegible] 1979

Dctor Griffin installed; Dctor Ylvisaker elected

John R. Ylvisaker, MD, S treasurer for 12 years, the new president-elect of S. Doctor Ylvisaker, medl director of Pontiac St, eph Mercy Hospital after y years as a general surn, was elected by the 1979 IS House of Delegates meet- in annual session May 4-6 Kalamazoo.

During the same meeting, est P. Griffin Jr., MD, nt radiologist, was stalled as 1979-80 MSMS esident, succeeding Louis E. ideman, MD, Detroit-area liatrician.

Louis R Zako, MD, Dearborn ights family physician, was -elected chairman of the MS Council, and James H. sdel, MD, Port Huron obstetician/gynecologist, was ntinued as vice chairman of e Council.

James D. Fryfogle, MD, Deoit, was re-elected speaker the House, and David Siel, MD, Lansing, was reected vice speaker.

Other MSMS officers nominated by the MSMS Council and ected by the House are bert M. Leitch, MD, Battle eek, re-elected secretary; nneth H. Johnson, MD, Lanng, re-elected assistant cretary; Leland E. Holly, , Muskegon, elected treasur- to succeed Doctor Ylvisaker d Dean C. Carron, MD, Ann bor, elected assistant easurer to succeed Doctor lly.

In other elections, Thomas Berglund, MD, Portage; nald K. Crandall, MD, Muskgon, and Donald N. Sweeny Jr., , Detroit, were re-elected delegates to the AMA. Lee

ontinued on back page)

MSMS delegates reject proposal

Michigan physicians meeting at the 1979 MSMS House of Delegates annual session May 4-6 at the Kalamazoo Hilton rejected the BCBSM proposal for a new cost containment system.

The delegates rejected the proposal on the wishes of individual physicians across the state who voted "no" by a significant margin in a special poll.

In one of the most significant actions of the weekend, the House also unanimously approved a $60 dues increase for each member as recommended by the House Ways and Means Committee, to meet present and projected budgets and inflationary trends.

The proposal

The Blues proposal was a major topic of interest for the 1979 House of Delegates. During that meeting, the chairman of the physician work group which studied the proposal, Donald K. Crandall, MD, Muskegon, had the following assessment as he opened discussion Friday night:

"I feel this proposal answers many questions and problems of individual physicians the House has voiced over the past ten years.

"Yet it still has been overwhelmingly rejected by individual physicians answering the poll.

"So, it is time for this House to sit back and reassess its views."

At a MSMS Council meeting in Kalamazoo before the House of Delegates sessions, MSMS Legal Counsel A. Stewart Kerr described the pending FTC investigation of MSMS relationships with the Blues.

"The FTC wants us," he said. "They want to make an example of Michigan to prevent every state society and the AMA from ever having negotiations with third parties, particularly the Blues.

"Should the consent order be signed by MSMS in its present form, any speech or writing that suggests any effort initiated by the state society to negotiate with third party payors could automatically trigger a compliance hearing," he warned.

(Continued on Page 2)

(Continued from Page 1)

He outlined the alternatives open to MSMS regarding the consent order imposition. Agreeing to sign the decree in its current form would present severe problems for future society actions, he said, while attempts to work out changes in the consent order will take time, money and expert legal aid. He described the FTC's unwillingness to discuss the material conditions of the consent order as currently drawn.

Mr. Kerr was directed by The Council to continue his talks with the FTC.

Insurance programs

THE HOUSE WENT ON to call for a new study of fee-for-service systems under the direction of The Council and financed by MSMS. In addition, the delegates expressed their desire to continue to discuss improvement of health care for Michigan citizens.

THE HOUSE REAFFIRMED the physician's belief that an answer to cost containment is for all patients actually to pay part of the premium costs, and for all services in and out of the hospital to have a direct out-of-pocket cost to the patient, unless the patient is indigent as classified by the poverty level of US government statistics.

THE HOUSE SUPPORTED the AMA House of Delegates' efforts to implement a claim form for all third party payors, in the interests of convenience, computerization and speed.

THE HOUSE DISAPPROVED a resolution calling for removal of all physicians from the Blue Cross/Blue Shield of Michigan board, in light of the Council's earlier action supporting the concept of physician membership on the BCBSM board, for purposes of technical input.

Public issues

THE HOUSE VOTED to impress upon the government the critical importance of safe disposal of toxic waste, and urge the state to appropriate sufficient monies and talent to develop and implement a safe method of disposal of toxic wastes. The House further resolved that "no toxic, potentially toxic, or other waste be buried without consultation and approval of the local health jurisdiction and local county board of commissioners of the disposal site involved."

THE HOUSE RESOLVED that MSMS use all its influence and cause legislation to be introduced that would mandate revocation of a person's driver's license when he/she is proven to be driving under the influence of alcohol.

Communications

THE HOUSE RESOLVED to develop an educational and informational campaign emphasizing the positive aspects of the present medical care system to be used for the education of physicians, their patients and the public.

THE HOUSE RESOLVED that the Council investigate better means of communicating with non-members to inform and recruit them.

THE HOUSE INSTRUCTED The Council to review all facets of public relations and recommend to the next House of Delegates meeting specific proposals, with their fiscal impact, for increased activity.

To help members and the state society keep their goals clearly in mind in their communications efforts,

THE HOUSE ADOPTED a new statement of purpose for MDs, which it is urging the AMA to adopt. It reads:

"The physician's role is an individual and collective responsibility for preventative and curative personal medical care and community health of the highest level achievable.

"Physicians individually and collectively should voluntarily strive to restrain cost of treatment wherever possible without compromising quality care; but cost management can only be achieved through the combined efforts of physicians, hospital administration, other providers, third party payors and patients working together.

"A pluralistic health care delivery system should offer the patient a choice of means to medical treatment which is equitable to both patient and physicians.

"The best and most effective monitor of the practice of medicine and the competence of individual practitioners is peer review by respected members of the profession."

LEGISLATIVE REPORT. . . .

April 1979

In the introductory session of the 1979-80 Michigan Legislature, there have been 679 pieces of legislation introduced, 246 of which originated in the Senate and 433 in the House. Of these bills, fifteen are medically related and have received selected attention by the Michigan State Medical Society Committee on State Legislation and Regulations.

The Legislative Report contains an abbreviated analysis of the various bills, their sponsors, current status and the MSMS position if one has been formulated. Physicians and all other interested persons are encouraged to contact the MSMS Department of Government Relations for additional details or information regarding medically related legislation.

HOUSE OF REPRESENTATIVES

Proposed Legislation

1979

HB 4002 Amendments to the Anatomical Gift Act - Removal of Corneas
Sponsor: Representative Lucille Mc Collough
This legislation establishes a procedure by which a county medical examiner can authorize the removal of corneas for transplantation and research purposes in a case where an autopsy is to be performed. The medical examiner is mandated to make a diligent attempt to obtain permission from next of kin.
Status: The bill has passed the House and been referred to the Senate Health and Social Services Committee where amendments were suggested for the inclusion of pituitary glands and middle ears. These suggested amendments were rejected. Separate legislation allowing for removal of pituitaries and middle ears is anticipated.
MSMS Position: SUPPORT

HB 4058 Medical Treatment Decision Act
Sponsors: Representatives Hollister, Cramton, Bullard, et al.
This legislation was originally introduced during the 1978-79 session of the legislature. It legislates the individuals' right to accept or refuse medical treatment to prolong life. The bill outlines a form that an individual can sign to appoint an agent to act in his behalf if he is not in a condition where he can make the decision. The bill relieves the physician of liability if the family and appointed agent disagree on removing life support systems.
Status: House Public Health Committee - Public hearings
MSMS Position: SUPPORT

HB 4078 Legalization of Laetrile

Sponsors: Representatives Kelsey, Trim, Bennett, et al.

This legislation legalizes the manufacture, prescribing or administration of laetrile. The bill relieves the physician of liability or disciplinary action by the Michigan Board of Medicine if the patient's condition continues to deteriorate. There were attempts to amend the bill in the House to make laetrile available as an over-the-counter drug, this amendment failed.

Status: The bill has passed the House and been referred to the Senate Health and Social Services Committee where public hearings are being held.

MSMS Position: OPPOSE

HB 4085 Michigan Health Service Corps

Sponsors: Representatives Kennedy, R. Hood, Nash, et al.

This bill has been introduced in an effort to facilitate the retention of health care providers in health resource shortage areas. The proposed legislation establishes a loan program for matriculating students. Upon graduation, a forgiveness of the loan will be granted if the student provides health care in a shortage area for a specified period of time.

Status: Reported out of House Public Health Committee - Referred to House Appropriations

MSMS Position: POSITION NOT YET FORMULATED

HB 4187 Department of Social Services Appropriations (Medicaid)

Sponsors: Representatives Jowett and Ostling

This legislation appropriates $2.7 billion for the Department of Social Services, including physician reimbursement under the Medicaid program for fiscal year ending 9/30/80. There is a two million dollar reduction in the physician line item from the 1978-79 appropriation.

Status: House Appropriations Committee

MSMS Position: SEEKS TO AMEND

HB 4259 Office of Inspector General - (Social Services fraud)

Sponsors: Representatives T. Stopczynski, S. Stopczynski, Hadden, et al.

This legislation proposes the establishment of an Office of Inspecto General within the Department of Social Services to operate independently of the Department. This office would be charged with investigating all incidents of alleged social services fraud by applicants, recipients and employees of service providers, including medical fraud. Case studies would be forwarded to the appropriate prosecuting attorney for prosecution.

Status: House Social Services and Youth Committee

MSMS Position: POSITION NOT YET FORMULATED

HB 4262 Full Health Services

Sponsors: Representatives Terrell, Ryan, R. Hood, et al.

This bill requires all local health departments to provide for a hospital with full medical services in a city having a population over 20,000. Full medical services shall include obstetrical, pediatrics and emergency services.

Status: House Public Health

MSMS Position: POSITION NOT YET FORMULATED

HB 4340 Blue Cross/Blue Shield Reorganization Enabling Act
Sponsors: Representatives Ryan and Hollister
This proposed legislation would restructure the BC/BSM Board of Directors from 47 board members to 28. The new board would constitute approximately 74% consumer representation and 26% provider representation. The legislation would also establish six customer advisory councils throughout the state to serve as communication links between the Blue Cross/Blue Shield Board and five million plus subscribers.
Status: House Insurance Committee
MSMS Position: CLOSE MONITORING - NO POSITION YET FORMULATED

HB 4367 County Medical Examiners
Sponsors: Representatives Ostling and Varnum
This proposed legislation establishes that in counties with less than 50,000 population, the county medical examiner may be a licensed medical doctor, osteopathic physician, dentist, funeral director or nurse.
Status: House Public Health
MSMS Position: POSITION NOT YET FORMULATED

HB 4403 Comprehensive County Hospital
Sponsor: Representative Joe Young, Jr.
This legislation establishes a procedure by which the county board of commissioners of a county with a population in excess of 1,000,000 may establish a Comprehensive County Hospital, Health and Allied Medical Service Program. The established facility may be affiliated with a medical or nursing school.
Status: House Public Health
MSMS Position: POSITION NOT YET FORMULATED

HB 4436 Second Opinion on Surgical Procedures
Sponsors: Representatives Bennett and Kelsey
This legislation requires patients to supply a surgeon with a written opinion from another surgeon on the necessity of surgery before a major surgical procedure is performed.
Status: House Public Health
MSMS Position: POSITION NOT YET FORMULATED

SENATE

Proposed Legislation

1979

SB 7 Reciprocity for Canadian Physicians

Sponsor: Senator Bishop

This legislation would allow Canadian physicians to obtain Michigan licensure through reciprocity if the applicant meets the following criteria: Has no disciplinary action pending against him/her; is a graduate of an approved Canadian medical school; has achieved a passing grade on the Licentiate Medical Examination of Canada; has completed one year of post-graduate training in a board-approved hospital or Canadian AMA approved school.

Status: Senate State and Veterans Affairs

MSMS Position: POSITION NOT YET FORMULATED

SB 65 Therapeutic Use of Marijuana

Sponsors: Senator J. Hart, et al.

This legislation attempts to respond to use of marijuana in two areas. It establishes penalties for manufacture and sale of marijuana, and sets aside certain convictions that occurred within the last ten years. The bill also provides for physicians to prescribe marijuana for the treatment of glaucoma, asthma and to persons undergoing chemotherapy treatments.

Status: Senate Judiciary

MSMS Position: NO POSITION

SB 157 Medicaid Abortions

Sponsors: Senator Fredericks, et al.

This proposed legislation would prohibit abortions as a service provided to a recipient of medical assistance under this act, except if the abortion is necessary to save the life of the mother.

Status: Senate Health and Social Services

MSMS Position: OPPOSE

SB 185 Controlled Substances Therapeutic Research Program

Sponsors: Senator Monsma, et al.

This legislation would establish a Controlled Substance Therapeutic Research Program. This program would conduct research using marijuana to treat patients suffering with a life or sense threatening situation due to glaucoma or cancer chemotherapy treatments. Patients would have to be physician certified and then approved by a three-member patient qualification review board. Twenty statewide pharmacists will be designated for distribution to patients in the program.

Status: Senate Health and Social Services

MSMS Position: POSITION NOT YET FORMULATED

THE HOUSE RESOLVED that MSMS continue to cooperate fully with the AMA HMO study project, and that the MSMS Council consider a study for the creation of a support center regarding HMOs, IPAs and other group arrangements.

THE HOUSE RESOLVED that the MSMS Council identify the cost of various governmental regulations in the nation's increased total medical costs and work to place the responsibility for these increased costs where it belongs.

THE HOUSE RESOLVED that MSMS work with the Michigan Hospital Association to bring standardization and consistency to regulatory bodies.

THE HOUSE REFERRED to the Council its wishes to seek legislative changes or modifications in the Michigan Medical Arbitration Law to allow a one-time contractual agreement between the physician and his patient which would remain in force until rejected in writing by either side; to allow emergency patients to sign the arbitration agreement at the time of their registration in the emergency department and to ask the Michigan Hospital Association to urge its member hospitals to make special efforts to assist all hospital patients to be more aware of the arbitration option.

Malpractice

THE HOUSE RESOLVED to investigate the feasibility of providing insurance against litigation for physicians who participate in peer review activities.

THE HOUSE RESOLVED that MSMS develop and support...legislation limiting liability judgements for an individual practitioner to a sum that represents the amount of liability insurance generally available.

Miscellaneous

THE HOUSE RESOLVED to provide guidelines about the management of problems pertaining to the impaired physician, to encourage hospitals and county medical societies to establish Impaired Physician Help Committees composed of highly regarded physicians in the community; to encourage hospital medical staffs to establish protocol for bringing a rehabilitated impaired physician back to the active staff, and to encourage all Michigan MDs to look more perceptively and deeply at this problem so that a constructive, positive and not punitive action can be taken to guide our colleagues back to productive practices.

THE HOUSE ADVOCATED the modification of all portions of the new Public Health Code dealing with mandated continuing medical education, in the light of "considerable dissatisfaction with the current CME category requirements." The House also resolved that the MSMS Council through the CME Accreditation Committee review the current five CME categories "for the purpose of developing greater latitude in acquiring CME credit."

Constitution and bylaws

THE HOUSE APPROVED on final reading the elimination of MSMS specialty sections, and the representation of specialty societies in the MSMS House.

THE HOUSE APPROVED on final reading a procedure for expelling an MSMS member whose license is revoked, or who shall have been convicted of a felony in any state or federal court.

THE HOUSE APPROVED on final reading a clearer definition of the purposes of component medical society mediation committees, to make it clear they are not serving as a means of setting physicians' fees.

Ways and Means

The Committee reported it will make a thorough study of the methods of determining MSMS dues.

The Committee explained the $60 dues increase will in part replenish MSMS cash reserves. It reported, however, that if MSMS incurs expenses anticipated for the FTC matter, MSMS again will be faced with low operational cash reserves by the end of 1980.

(Full details of the MSMS House of Delegates deliberations will be printed in the coming unofficial summary of House actions, and the full Digest of Proceedings.)

(Continued from Page 1)

B. Stevenson, MD, Detroit, was elected an AMA delegate to succeed James C. Danforth, MD, Grosse Pointe Woods, who resigned.

The House re-elected to the Council Marion G. McCall Jr., MD, Detroit, first district; Justin L. Sleight, MD, Lansing, second district; William S. Jones Jr., MD, Menominee, 13th district, and Orville W. Oughtred, MD, Mt. Clemens, 15th district. William D. Walters, MD, Battle Creek, was elected to replace S.A. Yannitelli, MD, Battle Creek, who resigned from the 3rd district seat; Vickers C. Hansen, MD, Traverse City, to replace Adam C. McClay, MD, Traverse City, whose term expired for the ninth district, and Robert E. Paxton, MD, Fremont, to replace Leland F. Holly II, MD, Muskegon, from the 11th district. Doctor Holly now sits on the Council as an officer.

Elected alternate delegates to the AMA were Carl A. Gagliardi, MD, Detroit to succeed Kenneth J. Ray, MD, Trenton, who resigned, and Gerald H. Mandell, MD, Southfield, to replace Lee. B. Stevenson, MD, Farmington Hills, who moved up to a delegate position. Doctor Leitch, Battle Creek, and Doctor Siegel, Lansing, were re-elected alternate delegates.

Delegates give special awards to MD

"It gives me quite a tug to be here," said Robert J. Mason, MD, past president of MSMS, as he talked of his return to the 1979 MSMS House of Delegates annual meeting to be honored for 50 years of service as a physician.

Also among the 50-year honorees was Harold "Dutch" Meier, MD, Coldwater, former MSMS Council chairman, Harold Hiscock, MD, Flint, MSMS past president and D. Bruce Wiley, MD, Lansing, past MSMS secretary.

The House also presented awards to four presidents of national medical associations. They were Robert J. Carbeck, MD, Ann Arbor, president, Association for Hospital Medical Education; Meyer O. Canto MD, Bloomfield Hills, president, United States Sectio International College of Surgeons; Howard J. Dworkin, MD, Royal Oak, president American College of Nuclear Physicians; and George R. Mikhail, MD, Detroit, president, American College of Chemosurgery.

C. Allen Payne, MD, president, Michigan Health Council, accepted an award as leader of a state non-medical organization.

A special award was made to Herbert A. Auer, wh served nearly 20 years with MSMS before taking the post in January of executive vice president of the Michigan Health Council. Mr. Auer was deputy director of MSMS at the time of his resignation.

Bill seeks repeal of Physicians' drug license

Repeal is being sought of the Public Health Code section which requires physicians who routinely dispense drugs from their offices to obtain a drug control license from the board of pharmacy. Sen. Alvin DeGrow and others have introduced SB 374 calli for the repeal of Sec. 17745 of the new Public Healt Code. Future issues of Medigram will keep physician informed as to its progress.

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MSMS/PSG

Michigan Medicine

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Contents

May 1979

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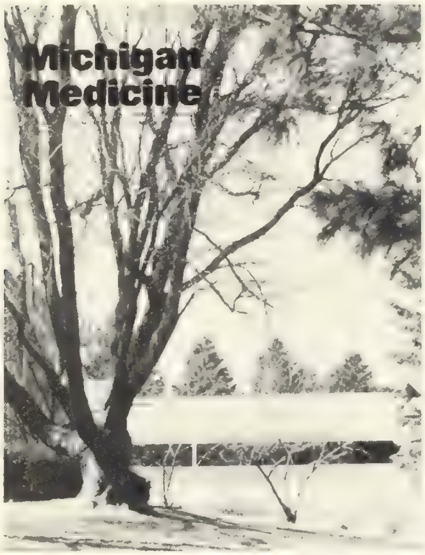

PHOTO BY MERT SCHOLTEN

The Cyrus Stockwell Building, right, new structure at MSMS headquarters, houses the MSMS Physician Service Group, Inc., subject of this month's special section beginning on the facing page.

Special Section

231 **The new MSMS Physician Service Group, Inc. (PSG) is organized and offering practice management consultations and financial and estate planning to MSMS members;** Leland E. Holly II, MD, and John H. Anthony

Features

235 **Detailed results of MSMS survey of Michigan MDs' professional liability coverage**

239 **HMOs change Michigan health scene;** Charles Downs

242 **Profiles of the Health Alliance Plan and Michigan HMO Plans, Inc.;** Nancy Perkin

249 **Photos and reports from the 1979 Michigan Conference on Maternal and Perinatal Health;** Nancy Perkin

264 **Implementing the Michigan Public Health Code;** Willah Weddon

271 **Doctor Coak sparks Adrian public health programs;** Willah Weddon

274 **Doctor Silva releases first album;** Judith Marr

Departments

237 **Medico-legal; Michigan's child abuse statutes;** A. Stewart Kerr

246 **Meetings**

252 **Ad index**

254 **MPMLC Clipsheet**

256 **Letters**

262 **News;** Katie Brewbaker

266 **Views;** Robert D. Burton, MD; Walter L. Howland, MD and Sandra L. O'Dell; Joseph E. Rich, MD

276 **Category I courses**

282 **Deaths**

284 **Classified ads**

286 **President's page;** Louis E. Heideman, MD

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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Physician Service Group established to offer more and better services to MSMS members

By Leland E. Holly II, MD
Muskegon

Two significant trends have prompted the Council of MSMS to establish The Physician Service Group, Inc. as a taxable, wholly-owned service corporation subsidiary to our Michigan State Medical Society.

The first is an increasing need for and provision of membership services outside of the clearly-established tax-exempt scientific and socio-economic needs and services of our state medical society. The second is an increasingly critical Internal Revenue Service attitude toward the 501 (c) (6) tax exempt status of organizations such as MSMS engaging in activities "unrelated" to the incorporated purpose of the association.

Well over a year ago, staff, legal counsel, officers and members of your Council considered various MSMS options for continuing to improve and increase membership service while at the same time retaining the vital tax exempt status for the Society. On May 4, 1978, the Society received the first of many reports from counsel and accountants indicating that a taxable subsidiary corporation could best do the job. It could assimilate all current and projected MSMS unrelated business activities, clarify the confusion of their accounting being mixed with that of our regular state society activities and divert the IRS interest.

In the meantime, staff researched similar structures established in other medical and professional organizations and identified a broad list of interesting membership programs which had met with success elsewhere. Brainstorming sessions and analysis of socio-economic data already collected by our Bureau of Finance added to this list.

Some of the proposed services indicated potential for significant MSMS income. All of these services would be beneficial to individual members of the state society or selected groups within the membership. Certain services would require limitations on legal liability. Conceivably, others might require that MSMS be shielded from possible anti-trust violations. MSMS could be exposed to the time (dollar)-consuming complexities of full financial disclosures of regular society business because of IRS investigation of certain of these membership services. Each posed special problems or threats which needed to be solved or side-stepped. All considerations reinforced MSMS need for a taxable subsidiary service corporation.

Control of this corporation belongs to the membership of MSMS and is achieved by making it a wholly-owned subsidiary with all outstanding shares owned by MSMS. The MSMS Council, which is responsible to the House of Delegates, represents MSMS membership and elects the directors to the board.

After careful reviews and revisions by the MSMS Finance Committee and the entire Council, the first meeting of the incorporator (Louis Zako, MD, representing MSMS) on Sept. 8, 1978 authorized adoption of the bylaws of the Physician Service Group, Incorporated, purchase of all its shares and its incorporation as a Michigan for-profit corporation. On Dec. 13, the second meeting of the incorporator elected seven directors as follows: Brock Brush, MD; James C. Danforth Jr., MD; J.K. Harness, MD; Allen F. Turcke, MD; Wilford E. Maldonado, MD; Leland E. Holly II, MD, and Warren F. Tryloff.

On Feb. 21, the directors of the Physician Service Group, Inc. (PSG) met and selected Doctor Holly as chairman, Doctor Harness as secretary and Doctor Maldonado as treasurer. The offices of PSG are to be located in the new MSMS Stockwell Building.

Perhaps the most important order of business occurred when the PSG

Doctor Holly, head of table, leads PSG board in organizational meeting. From left around table are Jay K. Harness, MD; Warren F. Tryloff; James C. Danforth Jr., MD; Doctor Holly; W.E. Maldonado, MD; Allen Turcke, MD (partly obscured); John H. Anthony, and A. Stewart Kerr, legal counsel.

Doctor Holly is chairman of the board of directors of the Physician Service Group, Inc.

Management consultations; financial planning among first PSG services offered

By John H. Anthony
East Lansing

The new Physician Service Group is designed to offer many important services to MSMS members. The highest priority always will be the provision of quality programs to physicians. The formation of the PSG, as a wholly-owned subsidiary of MSMS, allows for an expansion of the types of services MSMS can provide.

PSG background

After analysis of physician services currently provided, the MSMS Council concluded in mid-1978 that specific needs were not being met. Many services offered to Michigan physicians lacked quality, consistency, and universal availability. Physicians were subjected to and often made victims of poorly conceived and executed financial and practice management programs.

Recognizing these problems, the Council gave the go-ahead in September to the member service corporate subsidiary to fill the void.

Practice management consultations, fiscal and estate planning, member loan programs, computer usage analysis, group purchase plans, and a pooled pension trust program are just a few examples of the types of services the PSG has under study and hopes to make available.

Seminars first

The PSG concept was formulated several years ago when the personnel of the MSMS Bureau of Economics recognized the need for aiding physicians in their office management. The Bureau began by presenting seminars on various aspects of practice management. The classes always were well attended and especially well received. Physicians were constantly asking for more such activities and indicating large voids in their knowledge of the business side of their practices.

The Bureau proceeded to investigate other areas of concern to physicians.

Many individuals indicated they needed advice on the fiscal management of their practices and personal lives. So, the Bureau proceeded to establish seminars on fiscal management. These, too, were tremendously successful. The programs always were rated excellent by the standing-room-only attendees. Physicians would plead for additional personal financial advice. Unfortunately, the Bureau was unable to offer further assistance. The desire to provide added quality services and advice prompted the Bureau to recommend a corporation to research and develop new member service activities and programs.

The Council assigned the complete study of the propriety and feasibility of the Bureau's recommendations to

(Continued on the next page)

Mr. Anthony is general manager of the Physician Service Group.

DOCTOR HOLLY/*continued*

directors appointed John Anthony as the first PSG general manager.

The purposes of the corporation are as follows: 1) To engage in any activity for which corporations may be organized under the Business Incorporation Act of Michigan. This may include selling and leasing of services, supplies, medical equipment and office equipment, surveys, statistical data, and supportive services of any kind and character to physicians, laboratories, clinics, hospitals and other health servicing or provider persons, partnerships and corporations. 2) To purchase, own, sell, pledge, mortgage, or hypothecate real and personal property.

PSG directors also established some initial policy. Services would be developed for MSMS members and their employees. Competitive service charges would be levied in a manner to cover cost and provide nominal additional funds for research and development of programs to benefit MSMS membership. For the initial years PSG operational funds will be borrowed as necessary from MSMS to be repaid with interest. The corporation is expected to be completely free of this dependence in three to four years.

Six service programs were selected for initial implementation:

1) Financial and estate planning.
2) A collection service.
3) Loans to physicians through either bank or lending organizations.
4) Practice management consultation.
5) Practice management seminars.

The last two services have been in operation under the auspices of MSMS but are being transferred to PSG and will be expanded and more actively promoted. A large existing program managed by Helen Schulte under the Office of Special Services, which has provided administrative services to Michigan specialty societies, has also been transferred.

The directors and staff of PSG look forward to constructive criticism and suggestions regarding membership services from MSMS membership. They also expect MSMS members to appreciate PSG more as its reputation and valuable services grow.

PSG SERVICES/*continued*

the MSMS Finance Committee. Meanwhile, the MSMS Office of Special Services was providing secretarial and clerical functions for a growing number of specialty societies and other medical associations. But such services were prohibited by the Internal Revenue Service's new criteria for the determination and calculation of taxes on income earned by associations. The MSMS tax status is such that no tax obligations are incurred when dues revenue exceeds operating expenses. However, income generated by providing certain types of services is considered unrelated business income and is subject to taxation.

Tax status

After reviewing MSMS purposes, legal counsel advised that the medical society's current tax status might be endangered by the continuation of certain services already being provided and by the addition of the proposed new services. The Finance Committee and The Council felt there was a great need for the expansion of services to the physicians of Michigan, and therefore decided to establish the new PSG entity. Legal counsel was asked to design articles of incorporation and the corresponding bylaws for the new corporation.

At the September 1978 Council meeting the articles of incorporation were approved. The bylaws were adopted in December 1978. The first orders of business were the election of directors and the capitalization of the wholly-owned subsidiary.

Board members Doctor Harness, Mr. Tryloff, and Doctor Danforth listen attentively to Doctor Holly.

PSG board member Doctor Maldonado, General Manager Mr. Anthony and Legal Counsel Mr. Kerr consider a point.

The Physician Service Group will be staffed by a general manager, a director of financial services recently approved by the board, a manager of the division of special services, and their respective staffs. The general manager will be in daily contact with the executive director of the medical society and in weekly contact with the president of the PSG.

Special Services

The Division of Special Services is directed by Helen Schulte. Under her supervision are an account executive and three secretaries. Their primary function is to provide clerical, accounting, and other administrative services to the following organizations: American Association of Medical Assistants, Inc., State of Michigan; Michigan Association for Medical Educators; Michigan Ophthalmological Society; Michigan Psychiatric Society; Michigan Society for Respiratory Therapy; Michigan Society of Anesthesiologists; Michigan Society of General Surgeons; MSMS Auxiliary; and Organizational Executives of Michigan. Special Services is involved in membership record retention, membership directories, survey research, meeting facilities arrangement, recording secretary functions, dues and program accounting, and similar activities.

Practice management

The highly successful practice management seminars will be continued and expanded. The "Establishing Yourself in Medical Practice" workshop designed for senior medical residents will be provided each February. This two-day educational session covers everything an about-to-go-into-practice physician needs to know, from typewriter ribbon to proper legal form of practice. Personnel, patient flow, medical records billing and collections, general ledger accounting, and office space design all are covered in depth.

The seminars offered up to now on financial control in a medical practice will be expanded. These have been for practicing physicians in a half-day format and have covered billing and collecting, third party payments, and internal financial audits. They will be expanded to a full day and will include personal financial planning. The first set of workshops will be held on June 13, 14, and 15.

Consultations

A new area of endeavor will be on-site, in-office practice management consultations. These will be arranged so that both complete analyses and specific problem areas may be covered. The staff providing these services will have years of hospital, clinic, and physician office management experience. Their approach will be comprehensive and all-inclusive. Often, depending upon the size and type of specialty, a two to four-day period will be required to study the physician's practice and design changes that will resolve problems and create more efficient operations. These services will be provided on request and the costs will be on an hourly basis. Physicians who have made use of such services in the past felt the cost of the review was saved many times over by the implementation of cost-cutting measures and by the increased productivity of the operation.

Estate planning

The newest field of PSG interest is personal financial and estate planning. The board feels this area is the one in which most physicians need the greatest help. This division's activities will be headed by Robert T. Stanziano. Mr. Stanziano spent 25 years in bank trust operations and brings a wealth of financial and estate planning knowledge to the company. He has directed the financial affairs of many physicians and knows the proper and appropriate mechanisms to achieve the exact results physicians desire in their estate plans.

The area of financial and estate planning is complex and forever changing. Documents created only three years ago may not achieve any of the objectives of the original plan. This area of estate planning also is one filled with individuals who, even if they are well-meaning, normally have a bias because of some direct attachment to what they are trying to sell. There have been physicians who have purchased various financial vehicles and have had disastrous results. Oftentimes their heirs have been placed in unenviable financial situations because of misconceived and poorly thought-out trusts and/or annuity programs. Of course PSG will not be providing legal services or attempting to replace doctors' personal lawyers.

The PSG financial and estate planning division will meet with a physician and his or her spouse, determine objectives, decide future needs, design a program, and implement decisions and plans. This service will advise on the physician's current contributions to a Keogh plan or PC pension and/or profit sharing plan. It will analyze the physician's other assets, insurance plans, financial obligations, and make recommendations on each of these. The report will include the consideration of inheritance and gift taxes, lessening tax consequences, and mechanisms to avoid liquidity problems.

In addition, the financial and estate planning division will collect vital information on all bank trust operations: which are performing well, what their charges are, how the trustees function, and which provide the necessary continuing services. Answers to all questions on estate planning and will design will be provided, as properly designed wills and trust documents can save physicians and their heirs thousands of dollars.

A seminar on financial and estate planning is being designed now. It will be offered in the fall. Physicians will be encouraged to bring their spouses so both parties will have an understanding of this very complex field and will be able to secure the necessary professional services.

As was indicated earlier, one of the reasons the PSG was created was to provide added services to the MSMS members. Naturally, the list of possible services is endless. However, certain services are more desirable and will be developed in the near future.

Future projects

Among these is the physician pooled pension trust program, under development now. The MSMS Council has approved the creation of this service for members. It is being designed to provide an investment vehicle for physicians' and their employees' Keogh or PC pension contributions. The goal is to provide a trust agreement that will allow individual participants to allocate their funds to either a fixed income or equity investment option.

The use of a master trust agreement will reduce the annual costs to a physician plan. The proper government form completion will be done at a fraction of the current charges by accountants and lawyers.

The program will allow a great deal more flexibility than an investment in a bank trust plan or an insurance company program. The costs to the physician will be lowered and the quality of the plan's operation will be enhanced.

Programs that have received other medical societies' support and will receive the PSG board's consideration, include: member loan programs, a credit union for physicians and their employees, group purchasing plans, patient billings and collections, personnel agencies, computer usage consultations, group insurance programs, and real estate investment consortia. Each will be evaluated as to its value to MSMS members and to its possible savings in cost.

The PSG board is committed to the provision of necessary quality services at reasonable cost to the members of MSMS. Board members are confident the programs and plans will greatly benefit those physicians who make use of them. Each MSMS member is encouraged to become familiar with the services of the Physician Service Group.

MSMS survey reveals split among Michigan MDs in satisfaction with professional liability coverage

By John A. Richards, Chief
MSMS Bureau of Economics

The Michigan State Medical Society Bureau of Economics recently conducted a survey of all MSMS members regarding their attitudes on the malpractice insurance coverage presently available in Michigan. Out of the 918 replies to the survey, 52.1 percent indicated they were satisfied with the coverage presently available while 37.8 percent indicated dissatisfaction with the coverage available, and 10.1 percent had no opinion.

The relatively low number of responses to the survey may indicate physicians in general do not perceive a crisis in the availability of coverage. However, those responding to the survey strongly indicated cost is still a major concern as well as the lack of availability of umbrella coverage. When given five suggested improvements for the present coverage, 71.9 percent indicated the need for either $200,000/$600,000 or umbrella coverage, which is usually $1,000,000. Many respondents spontaneously indicated concerns regarding the high cost of the present coverage.

The respondents did overwhelmingly indicate satisfaction with the service they are receiving from companies presently offering insurance in the state. 76.3 percent indicated the service they receive from their carriers meets their expectatons, although many said since they had not been sued, they had no experience on which to base their opinions.

One interesting fact demonstrated by the survey is the indication by 26 of the respondents that they did not carry professional liability insurance. Projecting this 2.8 percent on the 9,000 active members of MSMS would mean approximately 252 MSMS members presently carry no insurance.

One difficulty with the results of the survey is the number of respondents subscribing to each insurance company was not in proportion to the actual distribution of subscribers among the companies offering insurance in Michigan. A disproportionately high percentage of returns were from physicians carrying insurance from the Michigan Physicians Mutual Liability Company.

Even with this flaw in the data base, it is still possible to consider the results fairly accurately represent how physicians in Michigan feel about the malpractice insurance coverage presently available.

The Bureau of Economics would like to thank the physicians who responded to the survey for the valuable information they provided. This data will assist MSMS in formulating future initiatives regarding this issue.

Results of 1979 Professional Liability Questionnaire

1. Are you satisfied with the present malpractice coverage in Michigan?

Yes	52.1%
No	37.8%
No opinion or response	10.1%
	100.0%

2. What improvements do you feel are needed in the coverage presently available?

a. Claims-made type policy	5.6%
b. Periodic premium payments	16.7%
c. Increased maximum coverage from $200,000/$600,000	21.4%
d. Umbrella coverage	50.5%
e. Lower coverage (e.g. $25,000/$75,000)	8.2%

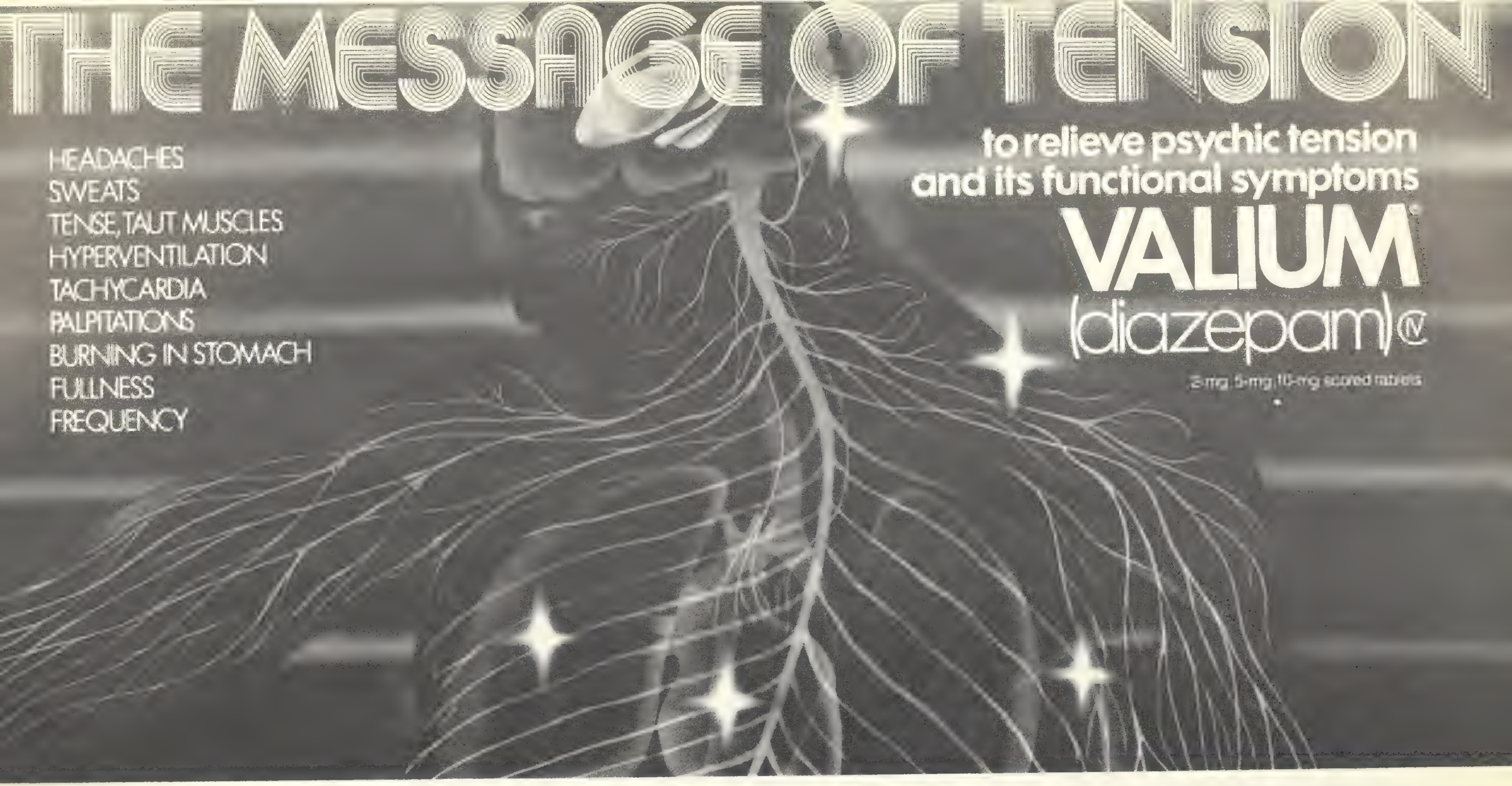
(Percentages total over 100% due to multiple responses to this question.)

3. Have you received satisfactory service from your present carrier?

Yes	76.3%
No	3.0%
No opinion or no response	20.7%
	100.0%

4. Which insurance company are you presently covered by?

Brown-McNeely	9.7%
Medical Protective	55.9%
Michigan Physicians Mutual Liability	26.6%
Other	5.0%
None	2.8%
	100.0%



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Here's a review of current laws regarding child abuse in Michigan

By A. Stewart Kerr
MSMS Legal Counsel

The Michigan statute covering child abuse is entitled the "Child Protection Law," and took effect on Oct. 1, 1975. The statute was one of the few which was not repealed by PHSRP.

The statute is basically a reporting law, delegating to those involved in the health care field the duty to report cases of child abuse to the Michigan Department of Social Services. Section 722.623 of the Michigan Compiled Laws Annotated requires physicians, doctors, dentists and nurses who have reasonable cause to suspect child abuse to report same to the DSS immediately. Within 72 hours, the person reporting such abuse must file a written report. Section 722.624 of the law further provides that persons who have reasonable cause to suspect child abuse or neglect may report the matter to a local law enforcement agency.

Identity confidential

Section 722.625 provides that the identity of the reporting person "shall be confidential" subject to disclosure only with the consent of such person or by judicial process. The section further states that any person acting in good faith who makes a report of child abuse or neglect "shall be immune from civil or criminal liability."

Such immunity, however, extends only to acts specifically required by the Child Protection Law, and does not protect the reporting person in the event he is negligent and causes personal injury or death. Significantly, if the reporting person is a physician, this Section 722.625 immunity does not cover malpractice which results in personal injury or death.

Section 722.626 provides that if the child is thought to have been abused or neglected and is admitted to a hospital or brought to a hospital for outpatient services, and the attending physician determines that release of the child would endanger the child's health or welfare, "the attending physician shall notify the person in charge in the department." The person in charge may detain the child in temporary protective custody until a preliminary hearing may be heard in a probate court of competent jurisdiction.

When a child suspected of being abused or neglected is seen by a physician, the physician has a duty to make necessary examinations which include x-rays, photographs, laboratory studies and other pertinent studies. The physician must further prepare a written report containing summaries of his evaluation of the child. If a report is made by a person other than a physician, or the physician's report is not complete, the DSS may request a court order for a medical evaluation of the child.

Section 722.627 requires the DSS to maintain a central registry system containing written reports, documents or photographs of child abuse cases to be kept confidential. The person who is the subject of a report may request, pursuant to the Act, that the director of the DSS "amend or expunge an inaccurate or unsubstantiated report or record from the central registry."

Section 722.628 of the law gives to the Department of Social Services the right to commence an investigation of a child suspected of being abused or neglected. In this regard, in a recent attorney general's opinion, No. 5406, dated Dec., 1978, it was held that under the Child Protection Law the DSS staff has a right to review hospital medical records of children allegedly abused or neglected.

In Section 722.629 of the law, the DSS must provide professional services such as those of a pediatrician, psychologist, public health nurse, social worker or attorney through the "establishment of regionally based or strategically located teams." The DSS must also initiate a continuing education program relative to the diagnosis and treatment of child abuse and neglect.

Interestingly, Section .722.630 mandates the courts in cases in which judicial proceedings are necessary to appoint legal counsel to represent the children involved. Also, Section 722.631 abrogates any attorney-client privilege between the child and his or her attorney.

Section 722.633 provides that anyone who fails to make a report of suspected child abuse or neglect under the law is "civilly liable for the damages proximately caused by the failure."

Finally, Section 722.634 provides that the practice of religious belief shall not alone be considered prima facie evidence of neglect, with, however, the right of a court to order provisons for medical services when necessary.

Federal Child Abuse Prevention and Treatment Law

On the federal level, the Congress in 1974 passed a child abuse prevention and treatment statute. The statute provides for the establishment of a National Center on Child Abuse and Neglect with certain designated responsibilities.

Michigan criminal statute

Finally, MCLA 750.136 of the Michigan Penal Code provides that a parent or guardian who is cruel to a child shall, upon conviction, be guilty of a felony.

The 1978 MSMS House of Delegates called for more education of Michigan physicians on their rights and responsibilities in child abuse and neglect cases.

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Special report

HMOs change Michigan health care scene

But IPAs offer opportunities for private practice

By Charles Downs
Special to Michigan Medicine

About 30 years ago, an elementary school principal and his wife lived next door to their family doctor and his wife.

Their pleasant relationship was flawed for the principal and his wife, as they felt they would impose on the physician if they discussed aches and pains. After some deliberation they decided to broach their problem to the other couple.

"That's easy to resolve," said the doctor after he had thought it over. "Suppose you just give me $100 a year and I will give you medical advice and care anytime, anywhere and I'll never send you a bill."

It proved to be a good solution. And in a very simple way, the doctor had established what is known today as a Health Maintenance Organization or simply, HMO.

The physician also had set up a sort of one-person Independent Practice Association, or IPA, the newest, and for many physicians, the most attractive of several HMO types.

For a prepaid fee, the doctor was offering a set of medical services, while still providing the patients access to the physician of their personal choice.

He was taking a risk that his prepaid patients would not fall ill with a serious disease or encounter a long stream of health problems that would cost him far more than $100. Presumably, however, the arrangement gave him a financial incentive to keep his prepaid patients healthy through preventative medicine.

It wasn't, however, the country's first prepaid health care plan. That distinction goes to the Ross-Loos Clinic in Los Angeles, which has provided both family and specialized health care for a fixed, periodic fee since 1929. And, after World War II, the large and very successful Kaiser plan was initiated in several West Coast cities.

Michigan HMOs

It has been only within the past five years that HMOs have begun to catch on and rapidly gain momentum in Michigan cities such as Detroit, Warren, Southfield, Lansing, Kalamazoo, Saginaw, Bay City, Muskegon and Flint.

Growth of HMOs has been aided and abetted by federal grants for planning and federal loans for implementation. This kind of encouragement was provided for by the 1973 HMO act. The Michigan law licensing HMOs was enacted in 1974. Follow-up has been rapid. Three plans were licensed in Michigan in 1975, four in 1976, two in 1977 and, though there were none in 1978, two have been licensed already in 1979 and two or three more may be licensed before the year is out.

Articles on this and the following page, as well as pages 242 and 243 describe HMO developments in Michigan.

Nationally, there are 212 HMOs, enrolling more than 7.7 million patients.

"What we are seeing is only the tip of what is to come," says Robert Brown of the Group Health Plan of Southeast Michigan. Brown was recently on the staff of the Michigan Insurance Bureau, which under Michigan law, is responsible for financial and administrative regulations pertaining to HMOs.

But despite the successes of HMOs and the growth that is expected to occur in the near future, most observers do not see HMOs as completely usurping traditional modes of medical care and causing economic hardship for private practitioners.

Moreover, private practitioners now have the kind of opportunity expressed by such adages as "Fight fire with fire" and "If you can't beat them, join them." The opportunity is the IPA, which combines the advantages of prepaid care with the convenience and choice offered by private practice.

Wide range of HMO models

One of the good things about federal and state HMO legislation — its redeeming virtue, some say — is the wide range of HMO models allowed. While the Kaiser kind of operation in which the HMO owns the hospital and provides outpatient services through a salaried staff is still the HMO stereotype, many other variations are being tried.

For example, an HMO may provide both hospital and medical care through contracts with other entities such as hospitals, laboratories, group practices, and, importantly IPAs. Such contracts may be either exclusive or nonexclusive.

IPAs can be big organizations composed of many practitioners or as small as a single professional corporation (PC). In other words, an HMO can elect to contract individually with many PCs or it may choose to work with one IPA representing many PCs.

Michigan HMO Plans, Inc. of Detroit is an example of an IPA model in which the HMO contracts with many PCs, each constituting an IPA. This HMO contracts with the state to provide health care for Medicaid patients who wish to participate. That is, the state pays the prepaid fee. Non-Medicaid patients also are enrolled through employee programs.

Out of the pool of money represented by the prepaid fee, Michigan HMO Plans budgets a certain amount for hospitalization and a certain amount for medical care. Each participating IPA, which can be as small as a two-man partnership, contracts to provide medical care for a stipulated annual amount knows as "capitation."

A percentage of the capitation is set aside to cover the cost of referral services not available within the IPA. Another percentage is set aside to cover such contingencies as greater hospitalization costs than anticipated and other risk factors. At the end of the fiscal year, the money remaining in the reserve funds is given to each IPA to use as it sees fit.

Genesee, Detroit HMOs contrast

In contrast, Genesee Health Care, an HMO established by Genesee Medical Corporation, is planning a different sort of IPA for Genesee and Lapeer County doctors. Along with negotiating contracts with area hospitals, it has established Independent Practice Associates, P.C. This is a for-profit corporation which expects to enlist the services of most doctors in the two counties.

Each doctor who agrees to participate will buy a $1 share in the corporation. The doctors will be paid for services provided to the HMO subscribers on a fee-for-service basis. The fee will be determined according to a uniform schedule for the entire area. However, 15 percent of the fee will be kept back to cover the risk if hospitalization or other costs will be higher than budgeted. If this contingency or risk fund is not needed, it will go to the participating doctors at the end of the fiscal year.

Holding back part of the doctor's income serves two essential purposes, explains Alan Schmick, director, health affairs, Genesee Health Care staff. The reserve provides an ample contingency fund and it also gives doctors a financial incentive to avoid over use of hospital services.

HMOs reduce hospitalization

It is in the utilization of hospital services that HMOs reduce health care costs, permitting them to offer more for less money than health insurance plans. Some observers believe that HMO's also cut costs by emphasizing health maintenance. While such advantages have been hard to document, there seems to be little doubt about hospital costs being a major factor.

Harold S. Loft, PhD, writing in the June 1978 *New England Journal of Medicine* notes:

"Enrollees in health-maintenance organizations have about as many ambulatory visits as comparison groups. Most of the cost differences are attributable to hospitalization rates about 30 percent lower than those of conventionally insured populations."

Doctor Loft also points out that "Total costs (premium and out of pocket) for (HMO) enrollees are 10 to 40 percent lower than those for comparable people with health insurance."

William O. Mays, MD, one of the originators of Michigan HMO Plans, puts it more succinctly: "You can buy a lot of ambulatory care for one day of hospital care."

Although some HMOs have financial problems, he notes that Michigan HMO Plans is in very good shape financially. One reason is that it was relatively inexpensive to start. It received federal money for planning and capital investment has been minimal.

"We do not have a dime invested in bricks and mortar," he says, "and we lease or sign agreements for almost everything we use."

Is less utilization good?

Less utilization of services has some doctors worried, including Doctor Donald Sweeney of Detroit.

"Fee-for-service practice," he says, "may lead to overutilization but HMOs may lead to underutilization."

In his capacity as a member (formerly the chairman) of the AMA's Council of Medical Services, Doctor Sweeney has been visiting HMOs around the country to gather data for a comprehensive study to be published next year.

He says he has not yet received and integrated enough data to come to firm conclusions but is "excited by learning things you don't get out of annual reports." Whenever he visits an HMO, he also visits the local medical society.

In addition to underutilization, Doctor Sweeney is concerned that some HMOs may be overusing physicians assistants, nurse practitioners and other nonphysicians.

In addition, Doctor Sweeney points out that not all HMOs are doing well and that some continue to have year-end deficits after as much as six years of operation. Part of the problem he contends, is that in HMOs in which physicians are salaried, many of the staff work only a 35-hour week or less. He also notes that some of these HMOs have a high turnover, leading him to believe that young doctors may be working for HMOs until they get a start and then go into private practice.

Nevertheless, Doctor Sweeney is favorably inclined toward HMOs. He contends that many physicians have a bias against HMOs and that this bias stands in the way of understanding.

He speaks from his own experience as a pioneer in group practice and a former trustee of the American Association of Group Practice. He comments:

"Group practice used to have a bad name, too, when it was new."

(More on pages 242, 243)

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Health Alliance Plan competes with Blues by emphasizing preventive care, group practice

By Nancy E. Perkin
Pontiac

The idea of an HMO in Detroit is nothing new. In 1960 the United Auto Workers founded the Community Health Association, an organization which offered to its members an alternative to Blue Cross/Blue Shield coverage. The association did not flourish, and in 1974 it joined with Blue Cross to form the Metropolitan Health Plan. Despite Blue Cross resources in administration, marketing, and management, the Plan could boast only 78,000 enrollees.

About the same time, Ford Motor Company officials, alarmed by the escalation of Blue Cross/Blue Shield premiums for their employees, brought in a Kaiser-Permanente study group from California to examine the feasibility of an HMO in Detroit. The group concluded that a market does indeed exist for an HMO that can offer good organization, adequate financing, and a significant health care provider.

Finding the provider was no problem. Henry Ford Hospital not only is the largest non-governmental hospital in the area, but its closed staff, comprehensive facilities, and traditional concern with maintaining close physician/patient relations could easily be adapted to the HMO concept.

Hospital administrators and officials concluded that a plan surely would prosper if combined with the UAW program. And so the stage was set for a merger of sorts: the UAW, a coalition of the auto companies, the Metropolitan Health Plan and its facilities at Metropolitan Hospitals, and Henry Ford Hospital and its satellites.

The Health Alliance Plan

The new plan, dubbed the "Health Alliance Plan," is similar in many ways to other health maintenance organizations. Individuals may subscribe, or employers may pay the monthly premium. The HMO receives a specified amount per year from subscriptions and must, within that budget, care for the population according to an agreed upon list of benefits. If costs exceed income, the HMO loses money. When payments exceed costs, the HMO retains the excess. Medical care facilities are located near subscribers. And, as suggested by the phrase "health maintenance organization," emphasis is on preventive care to keep patients out of the hospital.

While most HMOs offer benefits similar to traditional plans, however, the Health Alliance Plan faces competition from the extraordinarily comprehensive Blue Cross/Blue Shield benefits given Detroit's auto workers.

Thus the plan's administrators intend to emphasize prevention by offering some routine medical office care and preventive maintenance (e.g., routine physicals) as a benefit of the program. Marketing efforts also will stress the need for fewer out-of-pocket dollars; inducements for young families with increased need for health care services and for new patients who are without a physician; and the appeal of a group practice environment to those who prefer that all medical care is given in one place.

Why Henry Ford Hospital?

Administrators agree that transition to the plan will present few problems for the hospital staff. Staff members will not face the loss of fees for services because all are salaried. The hospital and its satellites, as well as the Metropolitan Hospitals and health centers, are readily accessible to subscribers. A group practice setting now functions in the hospital and its satellites. The notion of preventive medicine is not new, as evidenced by a long-standing emphasis on research and on the importance of good physician/patient relations.

How, then, will the hospital benefit from the conversion to HMO status?

Statistics on Detroit's current hospital use rate compare unfavorably to those of at least one successful HMO. While in Detroit the use rate for conventionally insured persons averages 1,100 days per 1,000 population per year, the Kaiser-Permanente group in California has seen a drop to less than 500 days for the same group and period. Length of stay in the two cases is comparable, but frequency of admission differs radically.

The incentive for HMO development is apparent to Health Alliance Plan administrators: cuts in hospital use rates free funds that may be applied to new preventive health care concepts (e.g., screening), which in turn may help to slow the increase in hospital costs.

The Health Alliance Plan was licensed late in February and became operational this spring.

Michigan HMO Plans, Inc. first IPA group model in Michigan

Michigan HMO Plans, Inc. is the brainchild of a small group of physicians, consumers, and businessmen who, in May 1971, formed the Detroit Medical Foundation, a non-profit organization aimed at researching the feasibility of establishing an HMO in metropolitan Detroit.

Motivated by what they saw to be a steady flow of patients away from doctors' offices and into the emergency rooms and outpatient clinics of inner city hospitals, the group sought an alternative health care delivery system.

A large and well-financed local staff model HMO didn't seem to offer the facilities and services needed by the local population. And so a different sort of HMO was created, one whose seemingly impossible goals were to enroll large numbers of private and Medicare and Medicaid recipients, rely on doctors in private practice using existing medical facilities, and prove economically sound.

MHMOP history

The history of Michigan HMO Plans, Inc. is a history of firsts. It was issued the first Michigan license as an HMO in December 1975. On April 1, 1978, it became the first federally qualified individual practice association (IPA) group practice model HMO in Michigan. In 1977, MHMOP was the first HMO to petition for and receive a 16 percent rate reduction from the Michigan Insurance Bureau.

Subscribers in Wayne, Oakland, and Macomb Counties now number 35,000, of which one-third are private subscribers and two-thirds are Medicaid recipients. As of March, the plan had contracted with approximately 600 physicians in 44 health centers and clinics and 40 hospitals (10 others are under active contract negotiations), and with 27 dental providers from the private market. Beginning April 1, a Medicare contract permitted MHMOP to sell coverage to those over 65, adding possible 10,000 new subscribers.

Administrators predict that stepped-up marketing efforts to private employers and state and municipal governments will bring the subscriber total to 50,000 by June.

MHMOP structure

MHMOP's founders created MHMOP's rather intricate organizational structure to meet the special needs of southeast Michigan subscribers and the requirements of an IPA group practice model HMO. A monthly capitation payment to a given IPA covers primary care services, including pediatrics, obstetrics and gynecology, family medicine, and general surgery, as well as laboratory and X-ray procedures. A risk-sharing retention fund totaling 15 percent of the monthly capitation is withheld as a hedge against overutilization and inflation. At the end of the fiscal year, unused portions of the funds are returned to the IPA group.

Referrals to other specialists, consultations, and hospitalization are paid for on a fee-for-service basis. Hospital payments are made from a single central fund. The specialist is reimbursed through another fund, known as the Consultation Referral Fund, set aside and provided by the IPA's monthly capitation. Fees are paid automatically until half the allocation is spent; a central committee on referral and consultation fees must approve spending of any portion of the remainder. If the cost is disallowed or the fund is exhausted, the fees are deducted from the IPA's capitation income. Residual amounts are returned to the IPA at year end.

Absence of a formal model for Michigan HMO Plans, Inc. necessitated a lot of imaginative and careful planning. One result has been an innovative system of checks and balances. Two such checks, one reviewing the quality of IPA facilities and administration and the other the subscribers' use of facilities, may help to explain the Plan's success.

A quality assurance program mandated by state and federal laws is administered by quarterly meetings of a central quality assurance committee and by monthly meetings of each IPA's committee. The IPA committees set standards for each center on such issues as the physical plant, scheduling, and clerical work. The central committee then implements and audits planwide standards based on these recommendations. Informal monthly meetings of the provider group presidents also help to assure quality while provoking some measure of peer review.

Perhaps the most cost effective procedure initiated by MHMOP is the "emergency hotline triage system." In an attempt to reduce the number of visits to the hospital emergency room and the attendant costs, the Plan operates an emergency telephone service 24 hours a day, seven days a week. Registered emergency medical technicians monitor calls on any medical problems that involve more than a routine office visit and make appropriate referrals. The system has reduced costs substantially.

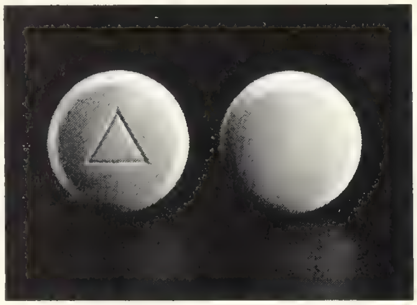
MHMOP future

What can be said about the future of Michigan HMO Plans, Inc.? At least one Plan administrator cautions that HMOs are not a panacea for all that is wrong with health care delivery today. He warns that stringent regulations make the HMO movement less competitive than it might be because costs of compliance are not borne by fee for service third parties.

Nevertheless there is an air of confidence in the MHMOP offices, and growth is inevitable. **NP**

The Maker

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand–name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Meetings

MSMS and AMA meetings

July 5-8 — MSMS Council, Birchwood Farm Golf & Country Club, Harbor Springs, contact: Warren Tryloff, MSMS headquarters.

July 22-26 — AMA Annual Meeting, Chicago Marriott Hotel, contact: AMA headquarters, 312/751-6000.

Sept. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24 — MSMS Conference on State Legislation, contact: Bruce Ambrose, MSMS headquarters.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters, 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other Meetings

May 13-19 — Licensed Practical Nurse Week throughout Michigan.

May 14 — Tri County Conference on Community Prevention of Child Abuse/Neglect, Kellogg Center, Michigan State University, East Lansing.

May 20-21 — Executive Committee, Michigan Ophthalmological Society, meeting open to all MOS members, at Wayne County Medical Society headquarters, 1010 Antietam, Detroit, contact: Susan Grimsley, MSMS headquarters.

May 23-25 — Annual Michigan Hospital Association Medical Staff-Trustee-Administrator Forum, Boyne Mountain Lodge, contact: Patric E. Ludwig, president, MHA, 517/484-7441.

May 29-June 1 — Annual meeting, Michigan Public Health Association, Grand Hotel, Mackinac Island, contact: Kenneth L. Klegon, executive director, MPHA, 403 Seymour, Lansing 48914.

June 15-19 — Association for Behavior Analysis 5th Annual Convention, Hyatt Regency Dearborn, contact: ABA Program Committee, Dept. of Psychology, Western Michigan University, Kalamazoo 49008, 616/383-1629.

July 7-12 — Annual Meeting, Michigan Academy of Family Physicians, Holiday Inn, Traverse City.

August — Emergency Services Deployment Seminar, Wayne State University, contact: Joanne Juhl, Wayne State University, 313/577-4707.

Tenuate® ⓒⅣ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

Product Information as of April, 1976

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References: **1**. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. **2**. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

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In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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April 1979

Education of all in perinatal service area key to good care, Maternal Conference speaker says

By Nancy E. Perkin
Special to **Michigan Medicine**

Nearly 750 health care professionals gathered to share ideas and experiences at the 18th Annual Michigan Conference on Maternal and Perinatal Health Feb. 28-March 1 in Dearborn. L. Joseph Butterfield, MD, director of perinatology at Denver's Children's Hospital, presided at the Wednesday afternoon session on "Patient Profiles — The Baby." The session featured speaker/audience participation in discussion of actual case histories.

IGRISAN
HALLITT
MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH

Donald E. DeWitt, MD, president elect, Michigan Academy of Family Physicians, talked during Wednesday afternoon session on "Patient Profiles — The Baby."

Seminar panelists included John W. Hallitt, MD, a practicing obstetrician/gynecologist and co-chairman of the conference planning committee; James D. Johnston, MD, director of the neonatal special care unit at Munson Medical Care Center in Traverse City; Donald E. DeWitt, MD, family practice coordinator at the SMAHEC Family Medicine Center in Kalamazoo and president-elect of the Michigan Academy of Family Physicians; and Rochelle M. Ingrisan, RN, regional perinatal nurse educator, BSN, Northern Michigan Hospitals, Inc., Petoskey.

Following remarks by Doctor Butterfield, each panelist presented a case history for analysis by the group. The forum allowed an exchange of ideas from the differing perspectives of physicians, nurses and administrators.

Perinatal systems approach

Focusing on identification and stabilization of high risk pediatric patients, Doctor Butterfield summarized the "perinatal systems approach" which has united perinatal units at all levels in Colorado.

An effective system, according to Doctor Butterfield, requires an established continuum of interhospital care and an organized approach to patient transport. Acceptance is the key:

"As the hospital health team accepts the concept of early recognition, stabilization, and transport when necessary, statistics show lower mortality rates."

Admittedly, there are pitfalls to an approach which requires the cooperation of regional care centers, outlying centers, and the community at large. Lines of communication must be kept open to allow input into planning based on local realities and to prevent the "springing" of new concepts on outlying centers. Political difficulties may arise with questions about who designates whom as a regional center and what is each center's function in the care continuum.

Outreach education effective

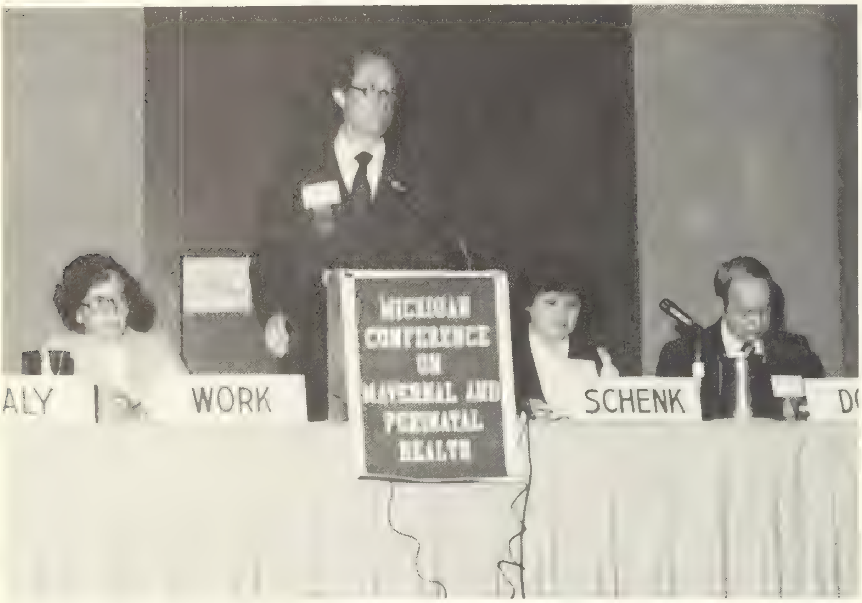
Doctor Butterfield suggests a general solution to these problems. "Without question, outreach education of all factions is the single most cost effective way to achieve good perinatal care."

As a regional perinatal resource center, Children's Hospital in Denver has undertaken to achieve the cooperation of the entire perinatal service area at all levels. A major aid has been March of Dimes funding which has allowed health care teams from Children's to work with lower level centers to train, consult, and act as "friendly visitors."

Concluded Doctor Butterfield: "It takes a long time to get people to communicate because of interprofessional, interhospital, and intercommunity behavior. Communication is the key. We've demonstrated that on a lesser scale at this conference. None of us is as smart as all of us."

(More on pages 250-252)

Maternal Health Conference participants hear announcement of child health advocacy panel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WORK
MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH
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D

Maternal Health Conference Co-Chairman Bruce A. Work, Jr., MD, opened the conference.

Nearly 800 nurses, physicians, students and others attended the 18th annual Maternal Health Conference, held this year at the Hyatt Regency Dearborn.

The concluding remarks at professional conferences often are doomed to obscurity by participants who are anxious to beat rush-hour traffic.

Such was not the case in the closing hours of the 18th Annual Michigan Conference on Maternal and Perinatal Health Feb. 28-March 1 in Dearborn. Perhaps it was the political nature of a subject like "Changing Concepts in Maternal and Perinatal Health" or perhaps the credentials of the panelists. Whatever the case, the audience was not leaving.

Presiding at the session was Lee B. Stevenson, MD, Farmington Hills, chairman of the MSMS Committee on Maternal and Perinatal Health and vice chief of Grace Unit, Obstetrics and Gynecology, Harper-Grace Hospitals, Grace Division. Featured speakers at the session were Warren H. Pearse, MD, Chicago, executive director of the American College of Obstetricians and Gynecologists; Vincent Hutchins, MD, a pediatrician representing HEW's Bureau of Community Health Services; and Dennis M. Paradis, East Lansing, director of the MSMS Physician/HSA Support Center.

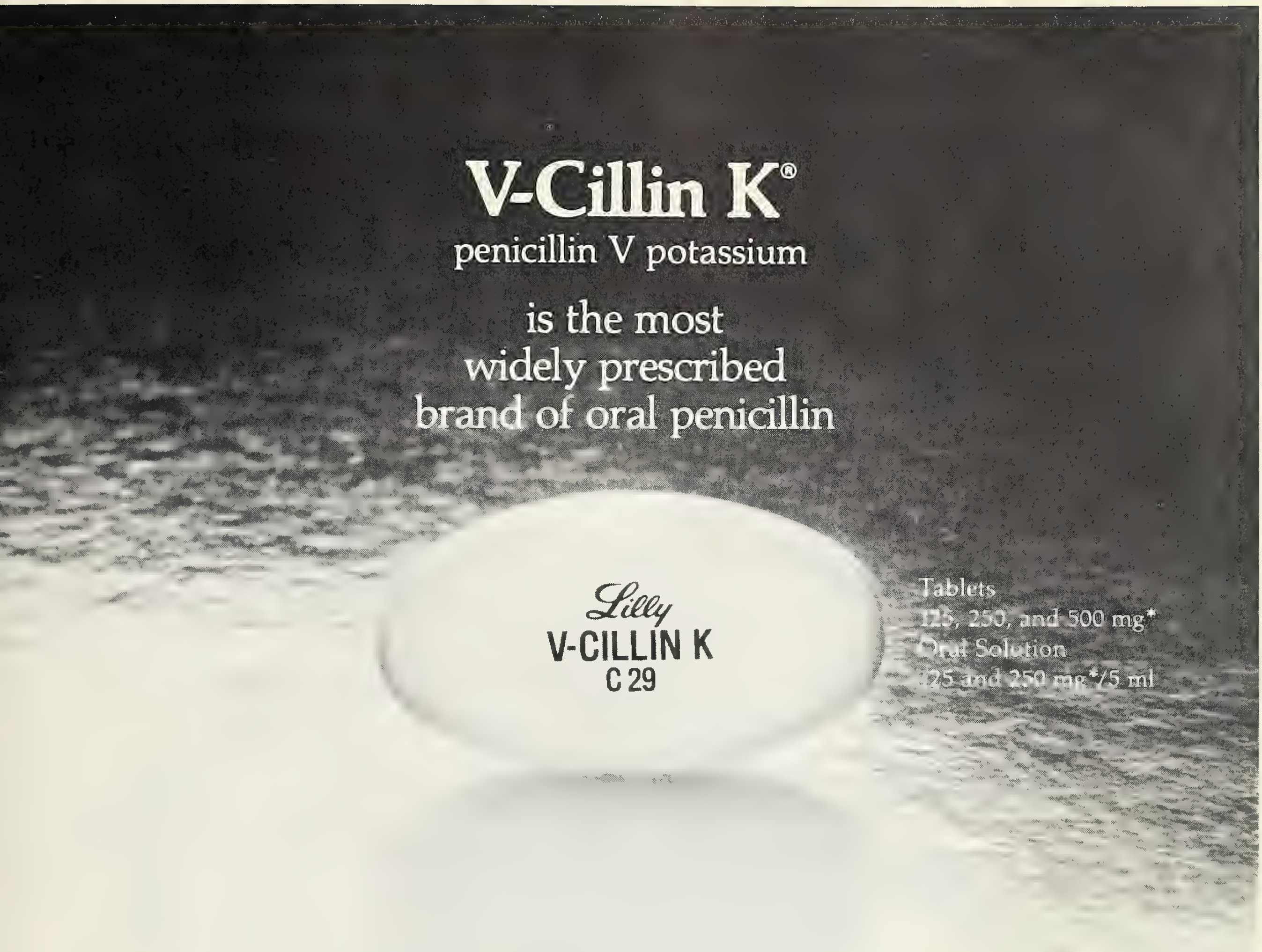
Planning participation

Paradis opened the session with a presentation on "Health Planning — Its Impact on Maternal and Child Health." The largely objective discussion traced the development of health systems agencies since enactment in 1975 of the National Health Planning and Resources Development Act.

While the major concerns of HSAs are cost, quality, and access, for which there are no objective criteria, lawmakers insisted that the decision-making process of an HSA board be objective, said Paradis. He was quick to note, however, that human nature makes this impossible.

For this reason, he encouraged maternal and child health advocates

(Continued on page 252)



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Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

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to become involved in HSA activities in order to influence the perceptions of HSA board members.

Stressing the importance of the HSA system to the future of health care, Paradis concluded: "The HSA is the anvil on which changes in health care will be hammered out."

Success a problem

Doctor Pearse, in his examination of the "Facts and Fantasies of Home Delivery," stressed one overriding problem: "We've become too successful. Mortality rates have fallen and people have come to believe that child birth is easy and doesn't require a hospital and trained personnel."

Careful to explain that U.S. data on the subject of home delivery is incomplete, Doctor Pearse nevertheless presented statistics on three areas of concern: untrained attendants, and care of high risk and low risk pregnancies.

An answer to the boom of home delivery among "naturepaths" may well be alternative environments within the hospital, he said.

"In any case," concluded Doctor Pearse, "the infant is not simply a means to an end. In maternity care, the infant is the end. We must believe that the desires of parents for a 'natural' environment must be secondary to our goals as health care professionals."

Child health panel

A new emphasis on linkage of health care programs within the Department of HEW was the major concern of Doctor Hutchins. His breakdown of the federal health care dollar revealed a growing emphasis on funding of maternal and child health care programs, particularly those involving adolescent care.

In a fitting conclusion to the conference, Doctor Hutchins announced the impending formation of a panel on child health care advocacy, a dream long held by members of the American Academy of Pediatrics and certainly an appropriate adjunct to a celebration in 1979 of the "Year of the Child." —NP

Michigan free-lancer writes book on Doctor Beaumont

A new book on the life of William Beaumont has just been published. Aimed at later elementary grade through adult readers, the book is by Lansing-area author Virginia Burns.

Entitled "William Beaumont: Frontier Doctor," the book originated with Mrs. Burns' interest in the Doctor when she taught years ago at William Beaumont School in Waterford Township, near Detroit. She now teaches fifth grade in Bath, north of Lansing. The book is illustrated with photos of Doctor Beaumont's instruments, owned by the Wayne County Medical Society, and of the Beaumont Memorial on Mackinac Island, established by MSMS. The photos are by Mrs. Burns' husband, Howard J. "Buck" Burns of the Department of Social Services.

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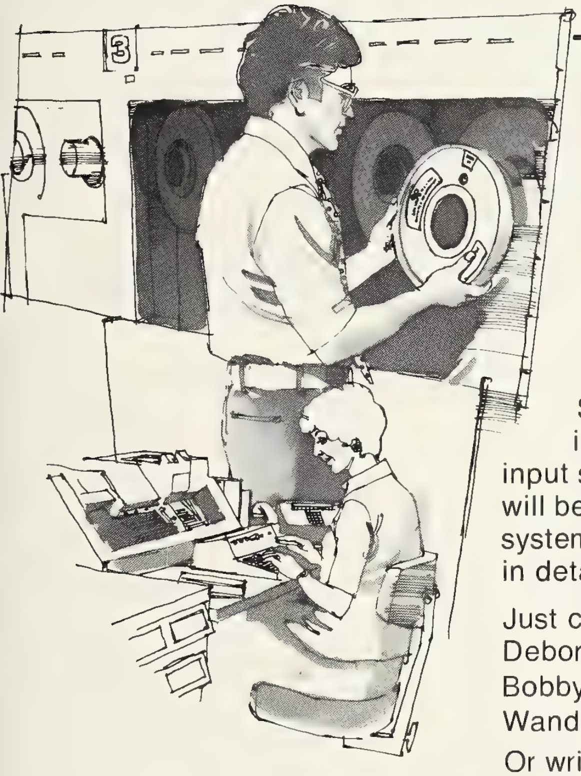

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MPMLC Clipsheet

MPMLC headquarters moving

Following is the fourth in a series of articles intended to better inform Michigan doctors about the Michigan Physicians Mutual Liability Company and its activities. Additional information may be obtained by contacting MPMLC at PO Box 1471, East Lansing, MI 48823; phone 800-292-1926 (toll free) or 517-351-1150.

MPMLC is on the move — literally! In late May, corporate headquarters will relocate to accommodate projected growth and allow more efficient operations and improved policyholder services.

The new floor plan and equipment will ease daily work flow, channelling of telephone calls, client visits, and meetings. For three years, MPMLC has occupied temporary quarters which have been less than ideal, and both MPMLC board members and management company employees look forward to the new work environment.

A branch office has been opened in Southfield to provide better service to physicians in the Detroit area. While not all services can be provided from the Southfield office, any Detroit area physician may feel free to contact either the main office in East Lansing or the Southfield branch for information, assistance, or referral to the proper person. The Southfield branch is staffed on weekdays from 8:30 a.m. to 5 p.m. An answering service takes calls when staff members are conducting business out of the office.

Where, When, and How to Contact MPMLC

Main Office

P.O. Box 1471
1305 Abbott Rd., 2nd Floor
(adjacent to Michigan State Medical Society)
East Lansing, MI 48823

(517) 351-1150
(800) 292-1926 new toll free WATS line

8:30 a.m. to 5:00 p.m.
Monday through Friday

Southfield Branch

18911 W. Ten Mile Rd.
Suite 101
Southfield, MI 48076

(313) 557-9490

8:30 a.m. to 5:00 p.m.
Monday through Friday

Not only a new location but also new services are planned for 1979. MPMLC will focus on wider dispersal of information and physician education through a number of new services, including:

- Travelling risk management seminars for groups of residents, county societies, and specialty societies
- A quarterly newsletter for MPMLC policyholders and other interested parties
- Informative pamphlets
- An expanded annual report for 1978

Anyone in or associated with the medical professions may request to be placed on the mailing list for printed materials by writing to the MPMLC main office, attention of Candace Worthington, Public Relations Coordinator.

Annual Neuromuscular Disease Symposium

Friday, June 1,1979; 8-5 pm.

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Quality is assured, of course. Our staff is highly trained, highly experienced, constantly made aware of new procedures and methods to improve their work, and supplied with the finest laboratory equipment available.

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From the business end.
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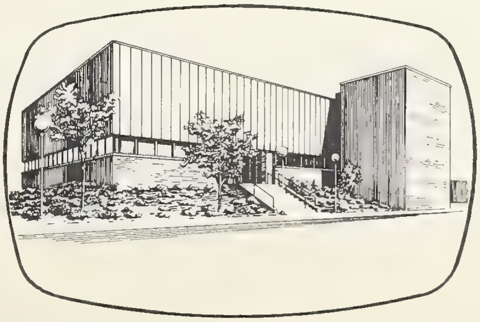

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Take up the challenge.
Compare our services and our performance against the lab you're using now. CBC has a lot to offer. If you'd like to know more, your area CBC representative would be glad to fill you in. It'll be worth it.

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Letters

" . . . mandated CME should be abolished"

Responding to the request in *Michigan Medicine* (February, 1979, page 89), I submit my view that state-mandated continuing medical education should be abolished.

No evidence has been put forth indicating that mandated education of medical doctors has improved the public health. No evidence has indicated that continuing education has been responsible for any change in litigation frequency. Abundant evidence indicates that accredited CME courses are becoming expensive. (note the charges, pg. 83 same issue.) The first seventeen average $7.11 per hour (with) and $7.52 (without) the single course in that series for which no tuition is charged. If travel, meals, and lodging account for $15 (at 25¢ per mile for a 60-mile round trip), $10 per day for food, and $20 for an overnight lodging expense, then one may estimate that it costs $87.11 per day for six hours of credit. This may be extrapolated to $725 per year approximately for 50 credit hours required by the state. A flight out-of-state (to coin a phrase) could triple the cost, while a visit to your hospital's program could reduce it.

In any event, government overhead attributed to policing and administration adds to our taxes and present ethics requirements for medical doctors suggest that the legislature not only wants to tell the profession to attend accredited courses, but prescribe course content as well.

All effort should be expended here in Michigan to repeal this needless law, one without demonstrable benefit to the public, yet demonstrably expensive to us all. I expect MSMS to spearhead a drive to repeal mandated CME this year. Other states are evidently recognizing the folly of CME. It is high time that this be done in Michigan.

My advice to MSMS thus is: MOVE. Do it. It can be done. Lead. Don't wait to be pushed. Act. Act now; tomorrow's problems may dwarf this. Solve this one now. Your membership doesn't want mandated CME any more than it wanted a notarized witness. It didn't want a witnessed CME form either. I doubt that it wants to study ethics at the mandate of the state. Get across the fine distinction to the state between education, which is for those in the 12th grade and below, and learning, the province of the older generation. Help to rid the state of useless rules and regulations . . . and laws. Let's help MSMS. Voice your views.

Richard A. Wetzel, MD
Department of Nuclear Medicine
William Beaumont Hospital,
Royal Oak

P.S. One might multiply the $725 per year per MD by the number of MDs in the state. I get over $9 million. What do you get? Certainly, a few hundred dollars of dues, or a few thousand this year to expedite the repeal of mandated CME would be economically sound. Don't you think so?

Michigan hospitals may be included in cancer study

The favorable response in 1977 and 1978 to the long-term and short-term patient care evaluation studies on cancer of the colon and cancer of the female breast has prompted the Commission on Cancer of the American College of Surgeons to ask hospitals to participate on a voluntary basis in a similar study of carcinoma of the rectum in 1979. Michigan facilities may be among those hospitals.

Charles R. Smart, MD, FACS
Assistant Director
Professional Activities (Cancer)

"CME . . . suffocates . . . "

CME is a TYRANNY! A tyranny represses freedom, stifles learning, promulgates uniformity, eradicates initiative, and, finally, suffocates all experiment and progress.

Andrew G. Wilson, MD, retired
Rochester

" . . . contact me to help prepare a synopsis of views (on) mental health"

I am writing to you in hopes I may stimulate a representative number of psychiatrists to respond and share their insights, impressions and recommendations about problems related to the practice of psychiatry in Michigan.

Each day I am impressed with how little emphasis there is on the psychological dynamics in disease, even by professional people, including physicians. Let's be sure that more non-psychiatrists have a greater opportunity to learn what psychiatry is really all about.

Let's strive to ensure more people will have a chance to hear from psychiatrists what psychiatry is all about. I believe we have too many non-psychiatrists describing psychiatry to lay people.

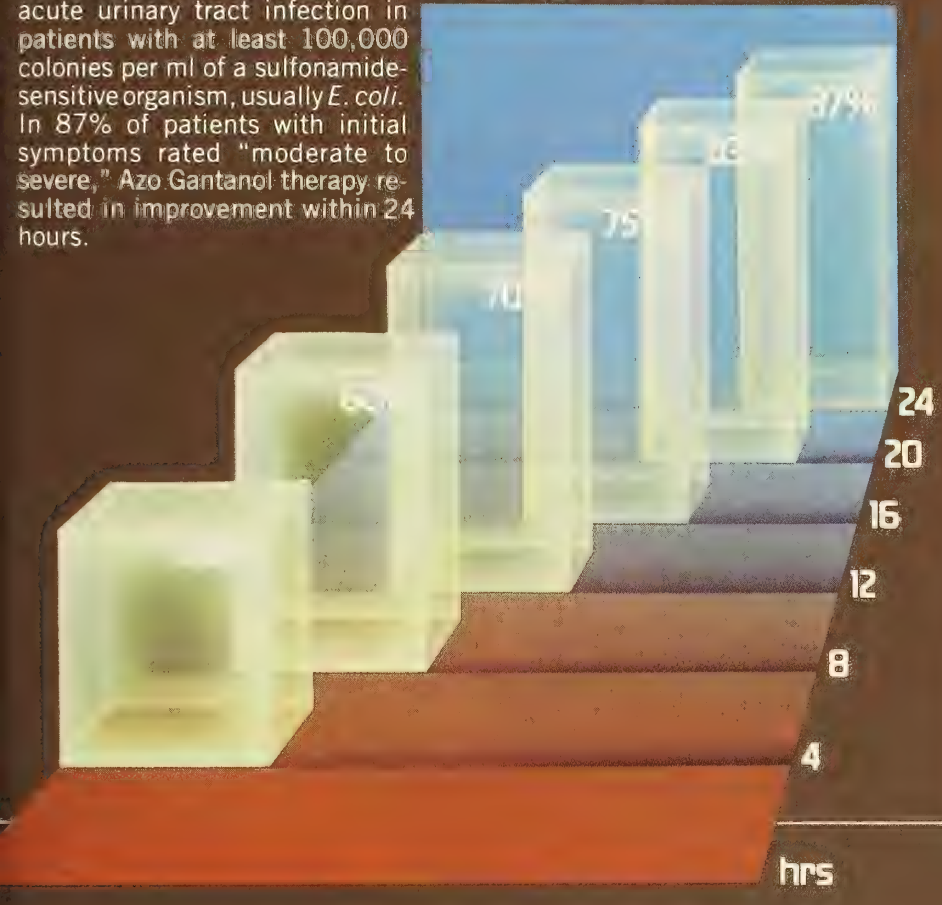
Input may stimulate us to clarify our insights, impressions and recommendations about the role of psychiatry in Michigan mental health. Therefore, I hope Michigan psychiatrists will contact me to help prepare a synopsis of their views concerning Michigan mental health.

Lawrence D. Stieglitz, MD
Kalamazoo

Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl

for the pain **for the pathogens**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

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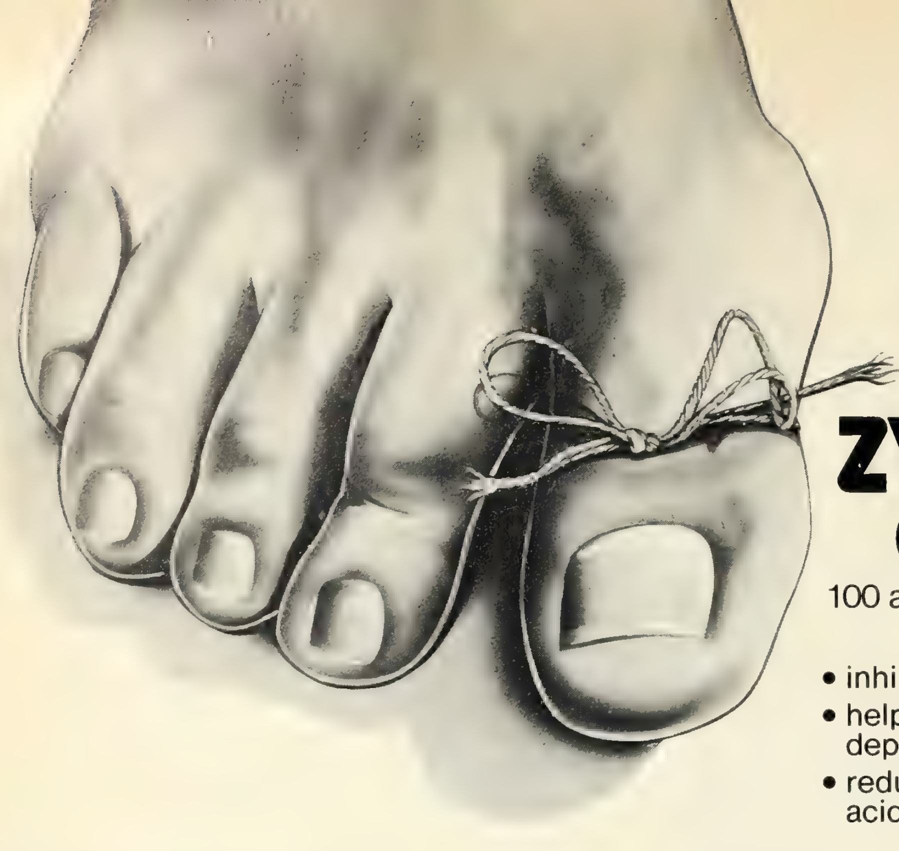
*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110



A reminder

ZYLOPRIM®

(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions, such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment [illegible] doses of Purinethol or Imuran should be made [illegible]sis of therapeutic response and any [illegible]

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

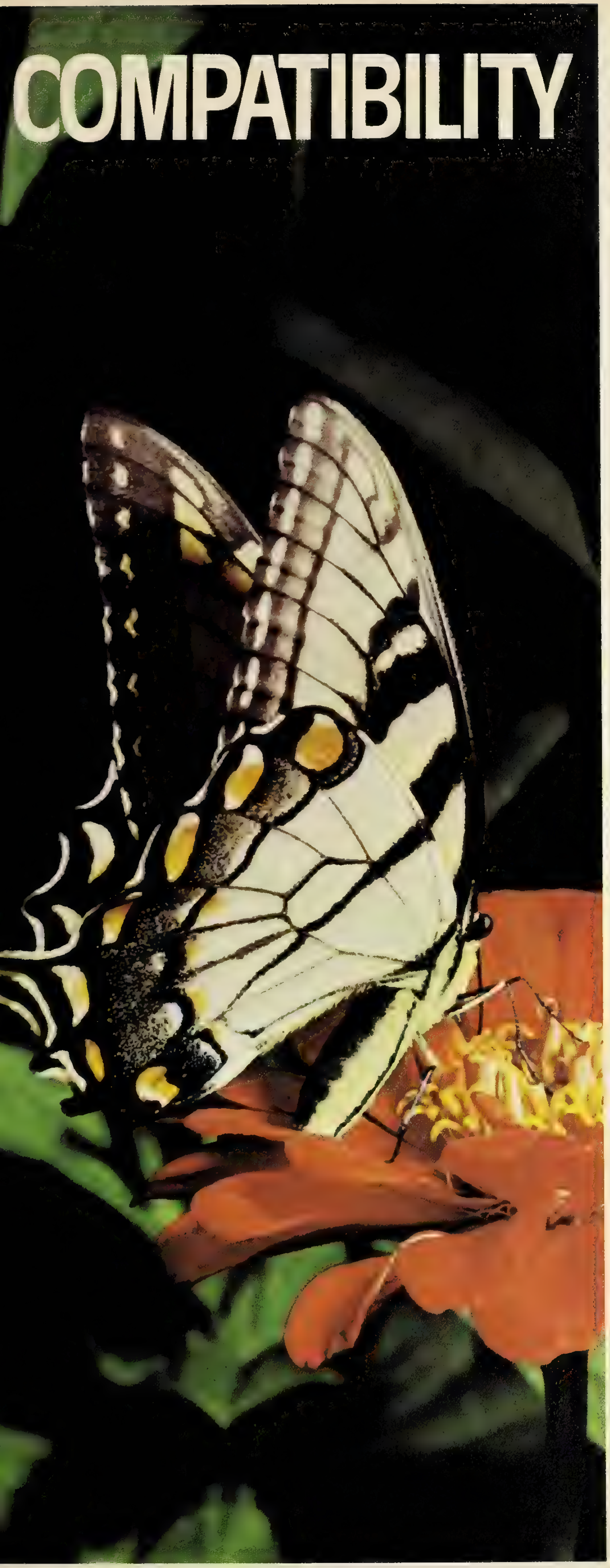
HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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When painful spasm is the presenting symptom…

..in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

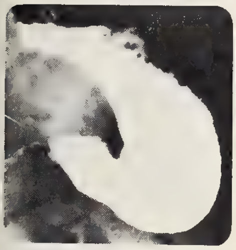
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

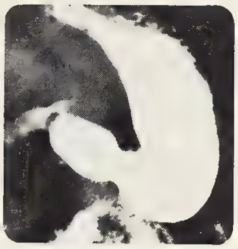
Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®
(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition
Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia; urinary hesitancy and retention, blurred vision and tachycardia; palpitations; mydriasis, cycloplegia; increased ocular tension; loss of taste; headache, nervousness; drowsiness, weakness; dizziness; insomnia; nausea; vomiting; impotence, suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs
Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily. *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults* 1 tablet three or four times daily Bentyl Injection: *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE. The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used
Product Information as of October, 1978

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U S A

Merrell
MERRELL-NATIONAL LABORATORIES
Division of Richardson Merrell Inc
[illegible]

News

Doctor Adams

Doctor Beer

Doctor Dworkin

Doctor "V"

By Katie Brewbaker, MSMS staff

Albert E. Posthuma, MD, Grand Rapids, has been elected president of the Kent Medical Foundation, a charitable trust founded in 1961 which offers financial assistance to Kent County students pursuing medical or health careers.

Alfred B. Swanson, MD, Grand Rapids, is the new president of the American Society for Surgery of the Hand. The society represents the specialty of hand surgery in the United States and Canada.

The University of Michigan Regents have approved the appointment of two new medical school department chairmen. **Douglas F. Adams, MD,** will serve as professor and chairman of radiology and **Alan E. Beer, MD,** professor and chairman of obstetrics and gynecology. Doctor Adams was director of cardiovascular radiology at Peter Bent Brigham Hospital and associate professor of radiology at Harvard University. Doctor Beer was professor of cell biology and of obstetrics and gynecology at the University of Texas, Southwestern Medical School, Dallas.

Vainutis K. Vaitkevicius, MD, of Pleasant Ridge, has been elected to membership in the Saint Vincent International Prize Jury for Medical Sciences, an international body of physicians comprised mostly of Nobel laureates.

The newly elected chairman of the AMA Commission on Emergency Medical Services (EMS) is **John A. Rupke, MD,** of the Butterworth Hospital Emergency Department in Grand Rapids. The Commission is composed of representatives from medical specialties involved in EMS systems and emergency services in hospitals, the Department of Transportation, HEW, and the American Hospital Association.

Recipient of the newly established Ransom Professorship of Surgery at the University of Michigan Medical School is **Norman Winslow Thompson, MD**, who will hold this distinguished professorship for the duration of his career at the U-M.

Certificates of appreciation were presented by the Michigan Department of Disabled American Veterans to **Forrest Byloff, MD**, **George Boyce, MD**, and **William Lindblom, MD**, at a recent ceremony at the VA Medical Center in Iron Mountain. The recipients were recognized for "exemplary consideration of America's war disabled through contributing actively, materially, and significantly toward their rehabilitation."

Added to the growing list of Michigan physicians serving in leadership roles with the American medical specialties boards is **Howard J. Dworkin, MD**, of Royal Oak, who recently was appointed to the American Board of Nuclear Medicine.

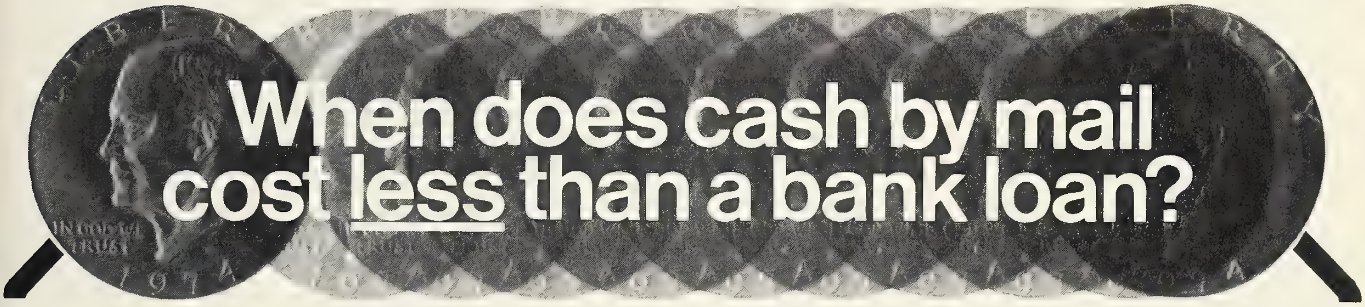
MSMS immediate past president **Vernon V. Bass, MD**, addressed the Michigan Professional Litigation Conference at the MSU Kellogg Center, East Lansing recently. The Conference was sponsored by the Michigan Professional Litigation Center and the Michigan Association of the Professions.

The Finnish-American Citizen of the Year award was presented to **Arthur L. Tuuri, MD**, of Flint, by the Friends of Finland in recognition of his 30 years of work in pediatrics and other community activities. Doctor Tuuri is a clinical professor of pediatrics at the University of Michigan Medical School and at the MSU College of Human Medicine.

The Jackson County Medical Society paid tribute to eight retiring physicians at the recent annual Renaissance Ball, at the Country Club of Jackson. Recognized for their service to the community were Doctors **Stanley P. Oleksy, Ray E. Newton, Earl E. Parker, William E. McGarvey, Sidney A. Beckwith, John W. Wholihan, Philip A. Riley, Sr.**, and **Ellis W. Adams.**

Michigan physicians continue to chalk up an impressive record as authors of articles in national medical publications. *Medical Economics* featured "I Look After My Patients' Health, Education, and Welfare" by Lansing internist **Richard C. Bates, MD**, in its Jan. 22 issue, and "How to Keep a Geared-down Practice Rolling Along," contributed by **Henry T. E. Munson, MD**, St. Clair Shores otolaryngologist, two weeks later in the Feb. 5 number.

JAMA also consistently publishes articles by Michigan doctors. Appearing in various February issues are "Diagnosis of Thyroid Nodules: Use of Fine-Needle Aspiration and Needle Biopsy" by **J. Martin Miller, MD**, **Joel I. Hamburger, MD**, and **Sudha Kini, MD**, of Southfield; "Legionnaires' Disease: A Cause of Lung Abscess" by Henry Ford Hospital physicians **Kumarapuram K. Venkatachalam, MD**, **Louis D. Saravolatz, MD**, and **Kent L. Christopher, MD**, and a commentary on "Should Phonocardiography Be Abandoned" was co-authored by **Arnold M. Weissler, MD**, from Detroit.



When does cash by mail cost less than a bank loan?

- when the prime rate is up
- when you are in a 40%—or higher—tax bracket
- when money is in short supply
- when capital gains tax requirements are relaxed

Hempel Financial Corporation has an office equipment sale/leaseback plan to provide you with *immediate funds* for a variety of uses and the benefit of *100% tax-deductible payments.* Your lines of credit are not affected, since all transactions are strictly confidential. For complete details and information on our other financial programs, send for our brochure by returning the coupon today, or call toll-free **(800) 421-7177;** in California, call collect **(213) 475-0304.**

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Volunteer health agencies discuss implementing Public Health Code

By Willah Weddon
Special to **Michigan Medicine**

Though Michigan's Public Health Code went into effect Sept. 30, 1978, there are many questions about how it will work.

A conference on "Understanding the New Michigan Public Health Code" was sponsored by the Michigan Health Council recently to try to clarify some of the code's changes.

Seventy representatives from organizations anticipating some degree of change due to the code were attracted to the day-long meeting in East Lansing.

Speakers included Toby Citrin, Southfield lawyer, who served as a vice chairman of the Public Health Statute Revision Project (PHSRP). Citrin pointed out he is concerned with two major factors: adequate public funding and adherence to the intent of the PHSRP committee during implementation of the code.

Documents used in formulation of the code have been preserved for reference to "intent," Citrin noted, and a Michigan Department of Public Health staff member will monitor future implementation. This is being done under a "Health Code Implementation Project" (HCIP) committee and is funded by the Kellogg Foundation.

Basic health services

Stuart Paterson, assistant to the director, MDPH and formerly with the Department of Social Services, pointed out the code provides for basic health services to be "available and accessible" to all who need them anywhere in the state regardless of their ability to pay.

Outlining the state framework for the use of cost-shared funds, slated to reach 50 percent, he identified three types of services to be provided by local health services administrations: mandated, basic and allowable.

To some observers, local health departments' requirements to obtain state funds appear to remove local control and create a "bureaucratic" pyramid. There does not seem to be much opposition to this from local public health officials, however.

William Ballenger, director, State Department of Licensing and Regulation, lauded the code, saying it allows more administrative uniformity within his department. Health profession licensing boards' responsibilities have been upgraded, he said.

For instance, a single system will receive all complaints, track them through investigation, board review and hearing action, to prevent accidental or purposeful delay or inaction. The department not only makes sure the substantiated complaint goes on the licensee's record, but that unsubstantiated complaints are removed after two years.

"We must communicate the disciplinary action to the insurance bureau and to the Department of Public Health, which in turn send notice to health care facilities and to other state and federal agencies," Ballenger said. "We hope to develop this flow of information into a reciprocating system whereby other agencies who also take disciplinary actions of a sort, will inform us of that action so we can evaluate the competence of a licensee."

Health Occupation Council

Eugenia Carpenter, assistant research scientist from the University of Michigan School of Public Health, described the Health Occupation Council (HOC) to which she recently has been appointed. HOC, established by the code, is composed of 30 members and is expected to have considerable influence, although no legal authority to enforce recommendations.

Among other duties, a major concern of HOC will be the issue of measuring "continuing competency," as required by the new code, she pointed out.

"This question of devising a system assuring that licensed individuals continue to maintain a minimum level of competency is a different one and an experimental approach has been taken to it," she said. "Within six years, the licensing board is authorized to establish pilot programs for a mechanism to assess continuing competency."

These pilots may include reexamination, continuing medical education credits, peer review and practice audits or a teaching evaluation mechanism as used in some physician-assistant programs.

"The Council is to appraise the pilot programs, study other approaches to assess continuing competence and recommend statutory changes to implement its findings," she said. "This may be the most difficult task the (HOC) Council will be undertaking."

Versions of reality

Jay Endsley, director, Office of Health and Medical Affairs, discussed the role of voluntary health organizations in the new code in a light and entertaining way. But there was a solemn warning in his concluding remarks:

"I commend your efforts, participation and cooperation (in the health planning and legislative process) . . . There will be great measures taken to intimidate your participation, to try to confuse, delay, stall, circumvent the issue . . . to distort your perception of what is going on. I'd encourage you to become heavily involved in the process, bearing in mind that your version of reality is at least as good as anybody else's."

Editor's Note: MSMS and the Michigan Hospital Association have contracted with independent writers to assemble a complete description of the code in layman's language which should be available by early summer.

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Second opinion programs need analysis before expansion

Doctor Burton

By Robert D. Burton, MD
Grand Rapids

Recently a lawyer friend told me that when 10 lawyers are assembled in one room, it is not difficult to find 10 different opinions on most any topic. Any person with an amount of capital for investing will be hard put to find one or more stockbrokers or investment bankers who will agree on a similar vehicle for investing that capital. If a person looks at the results of the last presidential election it is apparent that 49 percent of the American voting public did not agree that Jimmy Carter was the most suitable man to become the President of the United States!

Is it so surprising, then, that physicians should have differing views and enthusiasm for varying surgical procedures, especially when the opinions at times are obtained from both surgeons and non-surgeons? The amazing statistic is that the variation was only 11 percent in the original and oft-quoted study by Eugene G. McCarthy, PhD, of the Department of Public Health at Cornell University Medical College. This represented surgical procedures that were permanently deferred.

The doctors' view

The question, then, is whether second opinion review programs are truly cost effective? Or, why not obtain additional opinions on all forms of therapy other than surgery, such as medical, radiologic, psychologic therapies and others, as suggested by C. Rollins Hanlon, MD, director of the American College of Surgeons?

That some surgical procedures should be eliminated will get general agreement from most practicing surgeons. The six categories developed by SOSSUS (Study of Surgical Services for the US) include certain procedures that have fallen into disrepute. Elective procedures can evoke a difference of opinion. These may not be classified as lifesaving, but are concerned with making life more useful, more bearable, or more enjoyable.

Most practicing physicians seek consultation and a voluntary second opinion from a trained physician when the situation warrants or when the patient or the patient's family requests it. Basing benefits of certain insurance carriers on mandatory second surgical opinions of non-surgically trained physicians or a panel that may have allegiance to that carrier introduces the factor of having the patient choose the cheaper alternative. Also, the medico-legal ramifications of avoiding recommended surgery through an erroneous second opinion must be considered by the second opinion maker.

Unless direct and open communication between the first and second physician occurs, the reliability of information given by the patient may vary. Even under the best circumstances patients can misunderstand, misquote, and sometimes deliberately mislead a second doctor. A second opinion maker should be trained and qualified in the procedure to be decided upon, but this is frequently not the case. In the Florida HEW program, for instance, nine percent of the referral list are podiatrists!

Everyone has an innate fear of surgical procedures, anesthetics and hospitalization. Statements such as the December, 1978 House Interstate and Foreign Commerce Subcommittee's that it was "appalled at the amount of evidence of incompetent, as well as, unnecessary surgery" add to the patient's worry. Articles like the *New York Times'* series decrying "the problem of incompetent doctors" cause the public considerable anxiety. As stated by Pulitzer Prize winner, Vermont Royster, editor of the *Wall Street Journal*, the patient should expect his doctor's best judgment. He cannot expect him to be infallible.

The patients' view

A patient can and should request another doctor's opinion if he has serious doubts. Yet, when placed on a voluntary basis, these requests often are minimal. During the first two years of the Pennsylvania Blue Shield Consultation Program only three percent obtained a second opinion even though it was offered free of charge to them.

What's the way to go? Before any widespread compulsory second opinion program becomes a fixture in the medical care program of this nation, adequate pilot programs now in place should have careful and non-biased analysis. Criteria for operative intervention should be established, progressive experience through follow-up studies and adequate time evaluation data should be obtained. Above all, the medical profession and the public must realize the health dollar is limited and the maximal health benefit must be obtained from judicious use of it.

(References are available from the author.)

Doctor Burton is an otolaryngologist, an alternate delegate to the AMA, and a member of the MSMS Committee on State Legislation and Regulations.

Dropping some VDRLs saves money for this hospital

By Walter L. Howland, MD
Sandra L. O'Dell, ART
Bay City

At Samaritan Hospital in Bay City it was routine for many years to do a VDRL test on each patient admitted. In an effort to reduce the cost of medical care, the medical staff voted to discontinue the routine VDRL test on each patient. Because of concern regarding the quality of medical care, as well as the cost, the executive committee of the medical staff instructed the authors to perform a study of the problem at our hospital.

Samaritan Hospital, a short term, general medical and surgical unit excluding obstetrics with a total of 70 beds, is one of the three hospitals in the city.

A positive VDRL test was obtained in just 17 of 1,903 consecutively discharged patients from Samaritan Hospital (February through October 1978). Fifteen of these cases were confirmed by the MHA-TP test.

The average age of the 15 patients was 63.2 years. Ten of the 15 cases were expected to have a positive VDRL on admission. The five positive cases which were not diagnosed before admission were 22, 43, 65, 72 and 89 years old. The 65 and 72-year-old patients both showed evidence of tertiary syphilis in the form of aortic involvement.

The 89-year-old was not given additional work-up or treatment because of age and state of health. This means two unsuspected cases of syphilis were found and required treatment, which might not otherwise have been found.

Doctor Howland

Ms. O'Dell

Approximately 0.9 percent of our patients were positive for the VDRL test. Cohen et al in 1969 reported 9.5 percent reactivity to the VDRL test on 463 consecutive cases admitted to a large city general hospital in Atlanta (Grady Hospital). In 1976 Tomecki et al reported finding only 6.2 percent positive tests on patients in New York State (Buffalo General Hospital). At Buffalo General Hospital the test was not routine and was only ordered on 8.4 percent of the admissions so that it is a surprise to find the positive percentage so low as compared to the Atlanta study. Brown in 1971 reported on 38 million blood specimens tested and found 2.6 percent were reactive to syphilis.

Only three of our 15 patients were under 50. The two, ages 22 and 42, who were given treatment are in this group, along with a third 30-year-old patient who had received treatment for syphilis and was known to be positive before admission.

The total cost of testing 1,903 consecutive patients at $5.50 each was $10,466 in 1978. This means two unsuspected cases were found at a cost of $5,233 each. Was it worth it? We think it was but would like to suggest the following, which would have found the same cases at less cost.

We recommend tests be performed on all patients under 50 and over 14 who have not been admitted to the hospital in the previous two years (41.6 percent of our patients were under 50). By following this recommendation the cost per treated patient would be proportionately reduced and would cost $2,177, a saving of over $6,000 in a nine-month period in our 70-bed hospital.

How much would the saving be in your hospital?

(References are available from the authors)

Doctor Howland is a rheumatologist and is on the executive committee of the Samaritan Hospital medical staff. Ms. O'Dell is chief, Medical Record Department of Samaritan Hospital.

Partners of the Americas eagerly seek involvement of Michigan MDs

By Hector J. Inchaustegui, MD
Royal Oak

Partners of the Americas is an organization of national scope that was formed in the early 1960s, as part of the "Alianza Para el Progreso" of John F. Kennedy. Partners was the people-to-people part of the program.

The program was originally started among seven States and seven Latin American countries. Michigan was one of the pioneers and took British Honduras (Belize today) as its partner country. About seven years ago, a second country, the Dominican Republic, was added; Michigan is the only state that has two countries as partners.

Here are some of the things that we have done in Michigan:

We have sent to the Dominican Republic 10 emergency hospitals (the old M.A.S.H. units), to supplement and in some areas, establish clinics. These hospitals have gone to rural areas mainly. We have sent Ophthalmological equipment, X-ray units, and surgical equipment to hospitals and clinics throughout the Dominican Republic.

This year the "Beaumont Medical Corps" was formed, and in our first trip, six physicians and 28 nurses, and paramedical personnel traveled to the Dominican Republic and established contacts for continuing two-way programs between their hospitals and universities and William Beaumont Hospital.

We want to be able to send to Belize and to the Dominican Republic, more medical equipment, X-rays, incubators and surgical instruments.

We also want to qualify more paramedical personnel.

For all these things we need to grow. That is why we need your help.

Why not learn more about us, by writing to Norman Brown, MD, 175 South Anthony, Michigan State University, East Lansing, 48824, or to Hector J. Inchaustegui, MD, 4045 West 13 Mile Rd., Royal Oak, 48072.

Cost containment should start during medical education

By Joseph E. Rich, MD
Pontiac

The following is excerpted from the winning paper submitted to the Michigan Association for Medical Education for its 1978 essay contest on cost awareness and its relationship to postgraduate medical education. Doctor Rich delivered his paper at the 1978 MSMS Annual Scientific Meeting session on cost awareness and medical care.

As society becomes more sophisticated, increasing demands for economic accountability are being made on health professionals. Since health expenditures are expected to reach $234 billion per year, or more than 10 percent of the gross national product, by 1980, closer scrutiny is being given to the cost of the health care delivery system.

In the past, numerous attempts have been made by government to control health care costs. Government, however, would probably not have intervened had the nation's medical schools been more responsive to the social, economic and medical needs of the population.

The problem is that until recently, the concept of cost awareness has not been emphasized in medical training. Medical education focused on those tests and therapeutic measures considered best for the patient. However, cost awareness and high quality medical care need not be mutually exclusive.

In June 1977, the deans of 110 of the nation's medical schools issued a statement entitled "America's Health and Medical Costs: A Challenge to National Action." They stated their belief that increased cost awareness can be achieved without compromising the quality of medical care. They also said they "believe all physicians must become knowledgeable about the fiscal aspects of health policy and sensitive to the economic consequences of their professional decisions."

Cost training early

Since cost awareness is manifest in the physician's attitude toward diagnostic tests and therapeutic procedures, the time to initiate a heightened cost sensitivity in the physician is early in his or her training.

In the past, medical schools have taught students to utilize the full capacity of all technical services at their disposal, as an essential part of the patient's treatment or management; for educational purposes and to avoid claims of malpractice. In addition, patients frequently demand extra tests which may or may not be relevant.

Several studies in the past have shown a remarkable lack of knowledge regarding medical care costs on the part of house officers and medical students. In one study at the Medical College of Ohio, only one-third of the medical students and house staff could accurately assess the costs of tests they ordered. A similar study, when combined with an in-house educational program, significantly modified short-term but *not* long-term clinical behavior.

The difficulty occurs in defining what the "optimal amount" of testing is for a given patient with a given disease. This appears to vary greatly from setting to setting, with the academic centers utilizing up to one-third more diagnostic tests to obtain comparable diagnoses to those in community hospitals.

Attitude changes needed

To change these behavioral patterns, significant change in attitudes towards medical education and patient care, as well as the prevailing legal climate, need to occur.

Physicians-in-training can be made more responsive to medical care costs in several ways. Starting in the first year of training both formal and informal sessions could be held relating clinical diagnosis and treatment to the cost of services. With increasing seniority, the medical student and young house officer could receive itemized lists of all tests and treatments ordered where excessive costs were involved.

Greater emphasis could be placed on preventive medical services which are in most instances less expensive than clinically manifest disease. This is particularly true for those diseases related to life-style patterns.

If we as physicians are to avoid such drastic governmental intervention, and if we are to succeed in demonstrating to the public our concern for its social as well as physical well-being, we must develop techniques and teaching methods necessary to meet this challenge. For if we fail, such intervention must surely occur.

Cost awareness education must become a high priority in future postgraduate medical education. For it is the coming generation of physicians who will determine the utilization patterns and practices of medicine into the 21st century.

(Bibliography available from the author.)

Doctor Rich is a resident in the Department of Obstetrics and Gynecology, St. Joseph Mercy Hospital, Pontiac.

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Lenawee county physicians sponsor public forums on health

By Willah Weddon
***Special to* Michigan Medicine**

Nearly 20 years had passed since several Adrian physicians took part in a public panel-type program in which they answered residents' questions about health problems. Although there had been no repeat programs, Richard D. Coak, MD, remembered the interest the meeting had aroused and the large number of people who had attended.

When he was installed Lenawee County Medical Society (LCMS) president in February 1978, one of Doctor Coak's first objectives was to reinstitute a similar open forum, a model project which could be duplicated by other county medical societies.

He began by enlisting support of the local newspaper, the *Daily Telegram*, as a cosponsor. Carl Benz, MD, ophthalmologist, agreed to serve as committee chairman and plans were soon underway for an April public health forum dealing with various aspects of heart disease and modern treatment.

Doctor Benz, also chairman of the LCMS public relations committee, met for several sessions with Burke M. Gillespie, executive editor of the *Daily Telegram*, and two other committee members Richard Gilmartin, MD and Mr. Waldron Stewart.

Question coupons

They decided to run "question coupons" in the newspaper one month prior to the forum. These were to be filled in by interested persons and returned for discussion by panel members. Only these pre-submitted topics were accepted for consideration.

Carlton L. Cook, MD, Tecumseh, served as moderator of the panel which included internists James Feeney, MD; Ronald Isley, MD, and Chaudhary Idrees, MD. Fifth panel member was Julia Griewahn, cardiac nurse-clinician, of Emma L. Bixby Hospital.

"More than 500 people attended," Doctor Coak recalled enthusiastically. "Candy stripers, in uniform, served as ushers in Croswell Theater on that April Sunday."

Success of the event extended into several areas, he noted. Relations between the county medical society and community were strengthened and new insights for both society members and those in the news media were acquired. The event also provided the medical society with an opportunity to give information to help prevent heart disease and thus reduce future health care costs for people in the community.

More forums

"Another public forum is being planned, dealing with geriatrics and nursing care," Doctor Coak said. "It will concern practical aspects, such as where the elderly can go and who pays." Following this, a cancer forum is being planned.

A Jackson native, 54 years old and the father of four married children, Doctor Coak was a general family physician in Tecumseh for 12 years following his graduation from the University of Michigan Medical School in 1955. He then began studies in anesthesiology at Western Reserve University Medical School, Cleveland, Ohio, and upon completion began the practice of anesthesiology in Adrian's Bixby Hospital. During this past decade (eight of the years as LCMS secretary), Doctor Coak's natural friendliness has extended to his peers through the "LCMS/NEWS" which he writes, edits and prints every month or two.

"It takes a lot of time," he acknowledged with a grin, "But I enjoy getting out the paper."

In addition to these activities, Doctor Coak is Medical Director of Respiratory Therapy, serves as a pulmonary function consultant and is chairman of the continuing medical education program in Bixby Hospital. He also is taking part in the University of Michigan's Community Hospital Research Project which is experimenting with pulmonary function education to determine if there is any method of teaching fellow doctors other than the customary, conventional meetings.

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Hospital bill breakdown reveals what treatment costs

The table on this page reproduces the total hospital bill for a recent patient at a Michigan hospital. The patient had a fractured ankle, and required a closed reduction.

This breakdown, which does not include the physician's services, is presented here to help Michigan physicians better understand the high cost of medical care for an in-hospital patient. Phbysicians aren't always aware of the many related costs involved in hospital treatment of patients, and it is hoped this breakdown will make those costs clearer.

Description of Service	Total Charges
Room 7 Days @ 132.00	$924.00
Semi-Private 7 Days	924.00
Operating Room	132.00
Sub-Total	132.00
Recovery Room	45.00
Sub-Total	45.00
Anesthesia	12.00
Sub-Total	12.00
Med-Surg Supply	5.38
Sub-Total	5.38
Lab Hematology	9.00
Lab Urinalysis	8.00
Lab Chemistry	27.50
Sub-Total	44.50
EKG Standard	10.00
Sub-Total	10.00
X-Ray	16.00
X-Ray	16.00
Sub-Total	32.00
Drugs	18.33
Drugs	2.12
Drugs	51.17
Drugs	4.24
Drugs	33.19
Drugs	-37.52
Sub-Total	69.53
Phys Therapy	18.00
Phys Therapy	18.00
Phys Therapy	18.00
Phys Therapy	18.00
Phys Therapy	15.00
Phys Therapy	18.00
Phys Therapy	15.00
Phys Therapy	18.00
Phys Therapy	18.00
Sub-Total	156.00
Totals	$1430.41

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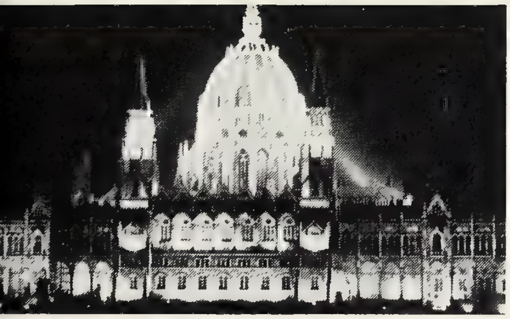

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Doctor Silva releases first album

Doctor Silva in promotional photo

By Judith Marr, Editor

Detroit surgeon Yvan J. Silva, MD, is developing an off-hours career as a popular singer.

And with his dark, handsome looks and smooth voice, there could be a new star on the entertainment horizon.

Last month Doctor Silva released his first album. Entitled "Dreams of My Life," for the title song, it carries the Lorio label.

The album includes popular hits "Shadow of Your Smile," "For Once in My Life," "If a Picture Paints a Thousand Words," "Sing a Song," "Bridges," and "Feelings," the latter sung partly in Spanish and Portuguese.

Three original songs also are featured: "Dreams of My Life," a soft ballad produced by Doctor Silva; "Acapulco Sun," a swinging, danceable song with Spanish flavor and lyrics by Doctor Silva and his wife, Bonnie; and "Song for Jason."

Lyrics to the latter are from the familiar Rudyard Kipling verse, "If." Doctor Silva has written his own preamble, which is spoken on the recording.

'Singing Surgeon'

Doctor Silva already has gained some recognition in the metropolitan area as "The singing surgeon." His earlier recordings of "Bridges," "Feelings," and "Sing a Song" have been broadcast periodically over Detroit radio station WJR.

Wayne State University School of Medicine seniors in May 1977 presented Doctor Silva with the Aesculapian Award, then shouted, "Sing, Sing!" Doctor Silva responded with selections from his early recordings.

Doctor Silva is an attending surgeon on the staffs of Harper, Hutzel, Children's, and Detroit General hospitals and is a full-time associate professor with Wayne State University.

He is active nationally on the board of trustees of the Education Commission for foreign medical graduates, and serves on the MSMS Public Service Committee and CME Programming Committee.

In addition, says Doctor Silva, "I've always been at home in the music world."

He began by singing Portuguese folk songs with his family at Christmas pageants in Goa, his native country. In his teens, the young Yvan joined a professional troupe and sang in Singapore, Hong Kong, Beirut and other Far East cities. During residency training at Vanderbilt and McGill Universities he worked as a performer in nightclubs, television and radio.

His wife Bonnie is a professional singer who performed with USO troupes and had her own shows. The two met when they bought neighboring condominiums in the Detroit area. They have three children — two girls and a boy.

"Singing is a very serious hobby with me," says Doctor Silva. "I like to write or acquire songs of original material, to improve their quality, to make them more sophisticated."

Medical thoroughness

Doctor Silva works at his music with medical thoroughness. He has a mike and tape recording system in his car, spends time in the control booth at recording studios ("I like to see how they handle the sound") and plays his own tapes "15, 16 different ways" to better gauge their "listenability."

Doctor Silva listens to a spectrum of music — pop, rock, classical and ethnic. "I can't stand some of it," he confides. "But it's like reading scientific literature. If you're in the profession, you have to keep up on what everyone else does."

He tries to make a new recording every three months. "That's just my speed — doesn't interfere with my work." With his own producer under contract, Doctor Silva only has to get the vocal track down. The producer then contracts for the instrumental tracks.

"As a song gets created, it gets more and more exciting," he says. "We have time to change things, to disagree on one or the other part. The exciting thing for me now is meeting more talented people, getting better material."

Doctor Silva keeps his music and his medicine apart, however.

"I make it a rule not to mention the singing in my office," he says. "A patient may ask, 'How's your singing coming, Doctor?' I say, 'Just fine. Now, what's the matter?' "

But with his progress, this surgeon may find himself in as much demand for singing as for incising.

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Form No. 989

Category I courses

Michigan Medicine ***each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.***

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: May 10-11, Ophthalmology Conference. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: May 10-11, Ophthalmology Spring Conference: Cataract Surgery. Location: Towsley Center for Continuing Medical Education, University of Michigan, Ann Arbor, MI. **Sponsor:** U-M Department of Ophthalmology. **Cost:** Physicians $150 or $80 single day; Physicians-in-training $80 or $45 single day. **Contact:** Towsley Center for Continuing Medical Education, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: May 10-11, Heart Days. Location: Kalamazoo Center, Kalamazoo. **Sponsor:** Michigan Heart Association. **For:** Physicians, nurses, therapists and all allied health personnel. **Cost:** Physicians: $50 (two days) or $30 (one day). **Contact:** Michigan Heart Association, P.O. Box LV-160, Southfield 48076. **Approved for:** 10 hours of Category I Credit.

Date: May 11, Neuro-Education Center Conference. Location: William Beaumont Hospital, 3601 West Thirteen Mile Road, Royal Oak, 48072, in Administrative Services Building Auditorium. **Sponsor:** Beaumont Hospital. **Cost:** $25. **Contact:** 313/288-2332. **Approved for:** 5 hours of Category I Credit.

Date: May 11, 12, Common E.N.T. Problems. Location: Radisson-Cadillac Hotel, 1114 Washington Blvd. at Michigan Ave., Detroit 48231, 313/256-8000. **Sponsor:** Wayne State University School of Medicine, Dept. of Otolaryngology. **For:** Primary care physicians. **Cost:** $120. **Contact:** Wayne State University School of Medicine, Div. of CME, 540 E. Canfield, 1206 Scott Hall, Detroit 48201, 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: May 12, Michigan Society of Pathologists May Seminar, "Mucosal Biopsy of the Gastrointestinal Tract." Location: Hurley Hospital, Flint. **Sponsor:** Mt. Carmel Mercy Hospital, Dept. of Pathology. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI or James W. Landers, MD, Dept. of Pathology, St. John Hospital, Detroit, MI. **Approved for:** 3 hours of Category I Credit.

Date: May 14-18, Head and Neck Oncology. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Otorhinolaryngologists, surgeons. **Cost:** $500. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: May 17, 18, Symposium on Glaucoma Surgery. Location: Detroit Plaza Hotel. **Sponsor:** Kresge Eye Institute and Dept. of Ophthalmology of Wayne State University. **Cost:** $150. **Contact:** Mr. Bud Prieur, CME, 313/577-1180 or Dong H. Shin, MD, PhD, program director, 313/577-1320. **Approved for:** 15 hours of Category I Credit.

Date: May 18, Infectious Diseases Symposium. Location: Grand Rapids. **Sponsor:** Butterworth Hospital, Grand Rapids. **Contact:** Butterworth Hospital Medical Education Office, 616/774-1835. **Approved for:** 7 hours of Category I Credit.

(Continued on page 278)

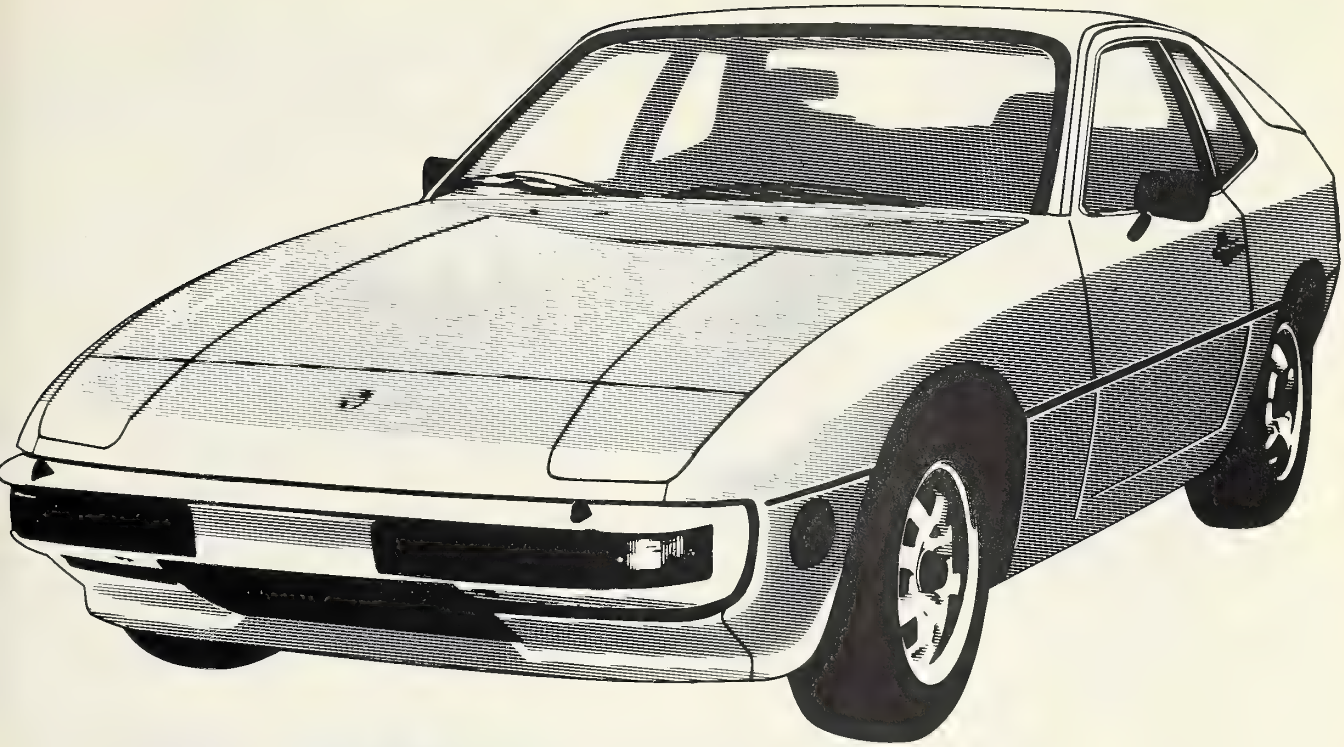
The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakwood Hospital, Dearborn
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti



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CATEGORY I/*continued*

Date: May 21-25, Advances in Internal Medicine. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Internists. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 30 hours of Category I Credit.

Date: May 21-25, Principles of Milieu Practice: Working with the Elderly in Treatment Settings. Location: Institute of Gerontology and School of Education, The University of Michigan/University of Michigan Medical School. **Sponsor:** U-M. **Cost:** $140. **Contact:** Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4102. **Approved for:** 30 hours of Category I Credit.

Date: May 23, "Orthopaedic Problems For The Non-Orthopaedist." Location: Kalamazoo Hilton Inn. **Sponsor:** Orthopaedic Section, Bronson and Borgess Hospitals, Kalamazoo. **Co-Sponsor:** Southwestern Michigan Area Health Education Center, 252 East Lovell Street, Kalamazoo. **For:** All Interested Physicians. **Cost:** $40 Advance Registration. **Contact:** Charles L. Zeller, Jr., MD, director, Continuing Medical Education, Southwestern Michigan Area Health Education Center, 252 East Lovell Street, Room 364, Kalamazoo 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 23, Rheumatology Day. Location: St. John Hospital, Education Center, Detroit. **Sponsor:** Continuing Medical Education Committee, St. John Hospital. **Cost:** $70. **Contact:** Ms. Linda Radu, Health Education Department, 313/881-8200, Ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: May 24-26, Workshop in Advanced Cardiac Life Support. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Office of Medical Education. **Cost:** $175. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, 313/876-1464. **Approved for:** 20 hours of Category I Credit.

Date: May 25, Exercising Your Patients, The New Role of Fitness. Location: Towsley Center for Continuing Medical Education, Ann Arbor, Michigan. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education in cooperation with The American Medical Joggers' Association, Great Lakes Chapter. **Cost:** $25. **Contact:** Office of Continuing Education, Towsley Center, Ann Arbor, MI, 313/764-2287. **Approved for:** 4 hours of Category I Credit.

Date: May 29, Use of Muscle-Nerve Biopsy in the Diagnosis of Neuromuscular Disease. Location: E131 East Fee Hall, Michigan State University. **Sponsor:** MSU Department of Pathology. **Contact:** Margaret Jones, MD, MSU Department of Pathology, East Lansing, 48824, 517/353-9160. **Approved for:** 1 hour of Category I Credit.

Date: June 1 and 2. Title: National Council on Alcoholism — Greater Detroit Area Annual Conference on Alcoholism Prevention. **Location:** The Michigan Inn, 16400 J. L. Hudson Drive, Southfield. **Sponsor:** National Council on Alcoholism — Greater Detroit Area. **For:** Those interested in workshops on Alcoholism in the family, in minorities, in the workplace, Alcoholism and early detection, prevention and the older adult, primary prevention through education, women and alcoholism, mental health and the alcoholism medical tract. **Cost:** $15 workshop registration fee. Luncheons extra. Credit cost assessed at conference. **Contact:** Pat MacDonell at 313/963-0581. **Approval pending for:** 5 hours of Category I Credit for medical tract. Wayne State University CEU available for workshops.

Date: June 7-8, Blood Banking. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $90. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: June 7, 8, 9, Annual Keyport Trauma Symposium. Location: Otsego Ski Club, Gaylord. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons. **Cost:** $25. **Contact:** B. E. Henig, MD, 308 Michigan Ave., Grayling 49738, 517/348-6611. **Approved for:** 12 hours of Category I Credit.

Date: June 8-9, 18th Annual Kidney Symposium. Location: Kalamazoo Center Hilton Inn, Kalamazoo. **Sponsor:** Michigan Kidney Foundation. **For:** All interested parties. **Cost:** $50 both days; $25 Saturday only. **Contact:** Hi Sung Park, MD, Michigan Nephrology Center, 1717 Shaffer Street, Suite 210, Kalamazoo, 49001. **Approved for:** 10 hours of Category I Credit.

Date: June 8-9, Neurological Update for Primary Care Physicians. Location: Benson Ford Education and Research Center, Henry Ford Hospital, Detroit, Michigan. **Cost:** $130. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 11½ hours of Category I Credit.

Date: June 11-12, Issues in Hospice Care for the Elderly: A Forum. Location: U-M. **Sponsor:** In-

(Continued on page 280)

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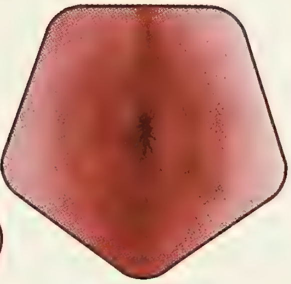
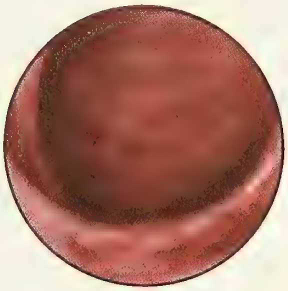
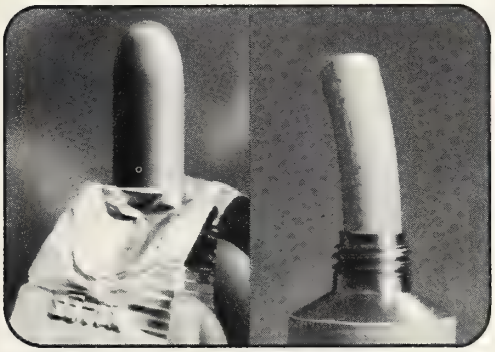


Pruritus ani



Proctitis

Anal fissures



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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg, bismuth subgallate, 2 25%, bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and certified coloring in a hydrogenated vegetable oil base

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22 5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

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Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

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Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

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CATEGORY I/continued)

stitute of Gerontology, The University of Michigan; The University of Michigan Medical School; and the United Way of Washtenaw County. **Cost:** $75. **Contact:** Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4102. **Approved for:** 11 hours of Category I Credit.

Date: June 17-23, Advanced Institute in Methods of Immunological Diagnosis. Location: Cranbrook Educational Community, Bloomfield Hills. **Sponsor:** World Health Organization Collaborating Laboratory for the Serology of Autoimmune Diseases at Wayne State University School of Medicine. **Cost:** $600. All inclusive. **Contact:** Noel R. Rose, MD, PhD, Dept. of Immunology and Microbiology, WSU School of Medicine, 540 E. Canfield, Detroit 48201. **Approved for:** 60 hours of Category I Credit.

Date: July 26-27, Coller-Penberthy-Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center, Traverse City. **Contact:** Norma Powers, Munson Medical Center, Traverse City, 49684. **Approved for:** 9 hours of Category I Credit.

Date: Aug. 10-12, ECG Interpretation and Arrhythmia Management. Location: Shanty Creek Hilton, Bellaire. **Sponsor:** International Medical Education Corporation. **Cost:** $202. **Contact:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. 800/525-8646 Toll free. **Approved for:** 15 hours of Category I Credit.

Date: Sept. 8, Diagnostic Problems in Neuropathology. Location: St. John Hospital, Detroit. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, or John G. Batsakis, MD, Dept. of Pathology, University of Michigan Medical Center, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: Sept. 10-Nov. 12, Pediatric Seminar IV. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 20 hours of Category I Credit.

Date: Sept. 26, Diabetes Update. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 28, Updating Core Knowledge in General Surgery. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

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August 17-19
Toronto, Canada

August 24-26
Hilton Head, SC

September 28-30
Las Vegas, NV

Coronary Disease, Exercise Testing & Cardiac Rehabilitation

May 4-6
San Diego, CA

June 8-10
Toronto, Canada

June 22-24
Reno, NV

July 13-15
Orlando, FL

July 27-29
Lake Geneva, WI

August 17-19
Cape Cod, MA

September 28-30
San Francisco, CA

*ECG Interpretation & Arrhythmia Management

May 11-13
Chicago, IL

May 11-13
San Francisco, CA

June 8-11
Atlanta, GA

July 13-15
Great George, NJ

July 27-29
Monterey, CA

August 10-12
Shanty Creek Resort, MI

August 17-19
Orlando, FL

Cardiac Rehabilitation

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Vail, CO

August 10-12
Lake of the Ozarks, MO

September 28-30
Washington, DC

- For information on these and other courses, contact: Director of CME, Dept. 7, International Medical Education Corporation 64 Inverness Drive East, Englewood, Colorado 80112/Tel: (303) 773-1144 or Toll Free (800)525-8646, ext 236

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Deaths

Anthony B. Chambors, MD
Harper Woods

Anthony B. Chambors, MD, 29, senior surgical resident at St. John Hospital, died March 10. Doctor Chambors, of Harper Woods, graduated from the University of Detroit in 1971 and received his MD degree from Wayne State University in 1975. He also was on the staff at Bon Secours Hospital, Grosse Pointe. Cause of death was given as stress due to overwork. Doctor Chambors recently won an award from St. John for developing a new surgical procedure for ulcers.

George Z. Gerras, MD
Flint

George Z. Gerras, MD, radiologist at Hurley Medical Center, died March 2 at the age of 57. Doctor Gerras graduated from the University of Athens School of Medicine in 1951, was formerly assistant chief in radiology at the VA Hospital, Ann Arbor, and an instructor in radiology at the University of Michigan. He came to Flint in 1965 and was a diplomat of the American Board of Radiology. He was a member of the American College of Radiology, Radiological Society of North America and Society of Nuclear Medicine.

Wellington C. Gibson, MD
Milford

Wellington C. Gibson, MD, former medical director of the General Motors Proving Grounds, died March 1 at the age of 70. Doctor Gibson, of Milford, also had been deputy Oakland County coroner and medical examiner since 1947. He was a graduate of Queen's University Medical School, Kingston, Ontario, and a fellow in the Industrial Medical Association and Academy of Family Physicians. He was past president of the Oakland Chapter of the American Cancer Society.

John R. Gruca, MD

John R. Gruca, MD, 40, an associate professor of internal medicine at Wayne State University School of Medicine, died Feb. 22. Doctor Gruca operated a practice in Utica for five years. He was a graduate of Wayne State University School of Medicine and a member of the Association of Internal Medicine. He was a member of the staff of St. Joseph Hospital East, Mount Clemens.

Mathias S. Hurth, MD
Lansing

Mathias S. Hurth, MD, who practiced in Lansing from 1919 to 1974, died March 21. He was 93. Doctor Hurth received his medical degree from the University of Michigan. He delivered more than 5,000 babies in his family practice, and received the B'nai B'rith Human Relations Award in 1968 for his approximately 30 years' volunteer service as high school team physician. He also received the Ingham County Medical Society Doctor of the Year Award. Upon his retirement in 1974, Doctor Hurth was recognized by the Michigan Legislature in a concurrent House and Senate Resolution for his dedication to the ideals of the medical profession and his humanitarian contributions.

Vernon P. Johnson, MD
Grosse Pointe Park

Vernon P. Johnson, MD, Grosse Pointe Park, died March 23 at the age of 79. A physician more than 50 years, Doctor Johnson was a member of the American and Wayne County medical societies and the American Academy of Family Physicians. He retired in 1978 after 53 years of practice in Detroit and St. Clair Shores.

Benjamin I. Johnstone, MD
Pleasant Ridge

Benjamin Irvine Johnstone, MD, died March 13 at the age of 81. Doctor Johnstone, of Pleasant Ridge, was a graduate of the University of Toronto, and was on the staffs of Henry Ford and Hutzel hospitals. Doctor Johnstone was a diplomate of the Board of Internal Medicine, a fellow of the American College of Physicians, member of the American Heart Association, past president of the Michigan Heart Association, and former secretary of the Wayne County Medical Society. He was also clinical associate professor of medicine at Wayne State University.

Roland L. Phillips, MD
Owosso

Roland L. Phillips, MD, Owosso, 51, was killed Feb. 24 with his wife and two of his four children when the plane he was piloting crashed in Grand Teton National Park, Wyoming. Doctor Phillips, an ophthalmologist, opened an office in Owosso in 1958. Born in Petosky, he was a graduate of Wayne State University School of Medicine. He specialized in eye surgery.

Sherwood Russell, MD
St. Johns

Sherwood Russell, MD, St. Johns, died March 19 at the age of 73. Doctor Russell was chief of surgery at Clinton Memorial Hospital for several years and a Clinton County physician for over 50 years. A native of Manistee and a graduate of the University of Michigan Medical School, Doctor Russell opened his practice in St. Johns in 1934. During World War II he was the director of a base hospital in London, England.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

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REFER TO PDR

Classified

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

PEDIATRICIAN: Board eligible or certified wanted as associate in private practice in mid-Michigan location, population 60,000. Two or three year contract: salary 1st year $40,000; 2nd $45,000 and 3rd $50,000. Additional malpractice insurance, hospitalization insurance and Medical association fees paid. Three weeks paid vacation. Immediate opening. Call 517/892-2517.

WANTED: Lab Technician IV position available at Oakdale Regional Center. Must be registered AMT or ASCP with at least two years of experience. Civil service benefits, 3 weeks vacation, 9 paid holidays, insurance programs and retirement plan. Salary $13,947.84 to $16,808.40. Contact the Personnel Office at 313-664-2951, ext. 410.

FAMILY DOCTOR Needed for rapidly growing Community M-59 and US-23 area. 1900 square feet available. Will divide if needed. Private bath. Immediate occupancy. Hartland, Michigan 632-6222.

WANTED: G.P. for small South Dakota community, 20 bed modern hospital, solo practice, good potential income. Call administrator, Bowdle Hospital, (605) 285-6146.

WANTED: Orthopod, Internist, Gynecologist; Full or Part Time, for evaluation work. High Income, No Hassles. Phone H. Lewis, MD, at (313) 767-2600.

MEDICAL DIRECTOR OF ALCOHOLISM THERAPY PROGRAM — The Department of Substance abuse of Henry Ford Hospital, a comprehensive health care delivery system that integrates clinical and basic scientific research and medical education with innovative health services in Detroit and its surrounding communities, is seeking a Medical Director for its Alcoholism Therapy Program. Duties will include supervising the medical care of a 14-bed inpatient unit at the main hospital and assisting in the development for a plan for a new suburban 50-bed residential and outpatient facility and providing inservice education and research. We offer a competitive salary and liberal fringe benefits. Interested parties should send their curriculum vitae, in strict confidence, to Bernard Schuman, MD, Chairperson, Search Committee, Department of Substance Abuse, 2799 West Grand Blvd., Office A573W, Detroit, Michigan 48202.

POSITIONS WITH STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the fall of 1979. Primarily interested in board certified or board eligible internists, orthopedists, and psychiatrists. Office locations at Lansing, Oak Park and Traverse City. Salary in mid 50's with approximately 23% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, M.D., Chief Medical Consultant, (517) 373-7330. In Michigan, call toll free 1-800-292-2710.

ORTHOPAEDIC SURGEON residency completed by July 1, 1979 and board eligible or board certified to do total joint replacement surgery and joint revision. Surgeon who has specific training in this area, and also has good background in internal medicine and interest in teaching. Salary forty-two thousand dollars ($42,000) per year. Contact Mr. Craig Suwinski, Assistant Administrator of Staff Services, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, MI 48202.

DERMATOLOGIST for a 300 + group practice clinic. Residency completed by July 1, 1979 and board eligible or board certified. Teaching background desirable. Will practice in a mixed setting: OPD Clinic, HMO and IPD residency teaching. Salary forty-four thousand dollars ($44,000) per year. Contact Mr. Craig Suwinski, Assistant Administrator of Staff Serices, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, Michigan 48202.

NEPHROLOGIST. Board certified in Internal Medicine and Nephrology to work in a large group practice setting. Research experience in pyrimidine nucleotide metabolism in the kidney in diabetes mellitus is a requirement. Interested persons should submit a curriculum vitae, in strict confidence to: Mr. Craig S. Suwinski, Assistant Administrator, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, MI 48202.

PEDIATRICS, Educational Program Director. Applications are being accepted for this full time staff position with the Southwestern Michigan Area Health Education Center. This is a challenging opportunity in a clinically stimulating environment with an academic atmosphere. To be considered, an individual must be a fully trained pediatrician and certified (or immediately so) by the American Board of Pediatrics. Duties and responsibilities will encompass many areas of activity including undergraduate, graduate and continuing medical education. A complete job description is available on request. Compensation will include a generous stipend and fringe benefits package as well as a regular appointment to the faculty of the College of Human Medicine of Michigan State University. For details Contact: Robert M. Nicholson, MD, Executive Director, Southwestern Michigan Area, Health Education Center, 252 East Lovell Street, Kalamazoo, Michigan 49007. 616/383-7896.

FAMILY PHYSICIANS — SOUTHEAST — Alabama, Florida, Georgia, West Virginia. Excellent private practice opportunities near hospitals with attractive monthly guarantee and free office space. Warm climate, good schools and outdoor recreation. Send curriculum vitae in confidence to: Mr. William Anderson, Search Director, 4470 Chamblee Dunwoody Road, Suite 350, Atlanta, Georgia 30338.

MEDICAL DIRECTOR, EMERGENCY DEPARTMENT — Immediate opening for qualified physician to assume position of medical director for the emergency department of progressive 460 bed hospital located in suburban community, eight miles from downtown Minneapolis. Primary responsibility and authority for professional supervision of active emergency department with emphasis on high quality patient care. Complete specialty back up, over 400 physicians on staff. Approximately 43,000 emergency department visits annually. Spacious new facility. Excellent salary and benefits through professional corporation. Strong individual with residency training in emergency medicine or surgery preferred, or other specialty with strong background and interest in emergency medicine. Forward curriculum vitae to Mr. Terry Finzen, Associate Administrator, Methodist Hospital, 6500 Excelsior Boulevard, St. Louis Park, Minnesota 55426, or call collect: 612/932-5015.

FULL PARTNERSHIP for F.P. Complete ownership, free, in no more than five years. Split all income evenly. Population about 120,000. All sports. Western Michigan. Four open-staff hospitals. Price $30,000. Terms available. Inquire to MSMS, 120. W. Saginaw, Box 13, East Lansing, MI 48823.

ORTHOPAEDIC SURGEON NEEDED for SW Michigan city. Modern progressive hospital; expansion underway; near state forests, Lake Michigan; rural setting minutes from major metro areas; recreational opportunities in a 4-seasons setting. Contact W. Trent, ADM., Allegan General Hospital, Allegan, MI 49010. Phone 616/673-8424, Ext. 311.

Positions Wanted

PHYSICIAN'S ASSISTANT — Seeking employment with solo or group practice. Four years of primary care experience. Nationally certified. Available immediately. Contact Charles E. Webster, 4608 S. Quarterline, Muskegon, MI 49444. 616/733-0684.

Miscellaneous

MAY 18-19 — Third Annual Postgraduate Course, DIAGNOSTIC ULTRASOUND. Sheraton-Southfield Hotel, Dr. William B. Steel, Program Chairman. Contact: Shirley Packwood, 2923 Woodslee Drive, Royal Oak, Michigan 48073. 313-494-7144.

DERMATOLOGIST — retiring this year, after many years in downtown Kalamazoo, Michigan. All equipment and practice offered very reasonably. M. B. Sofen, MD. (616) 344-0774.

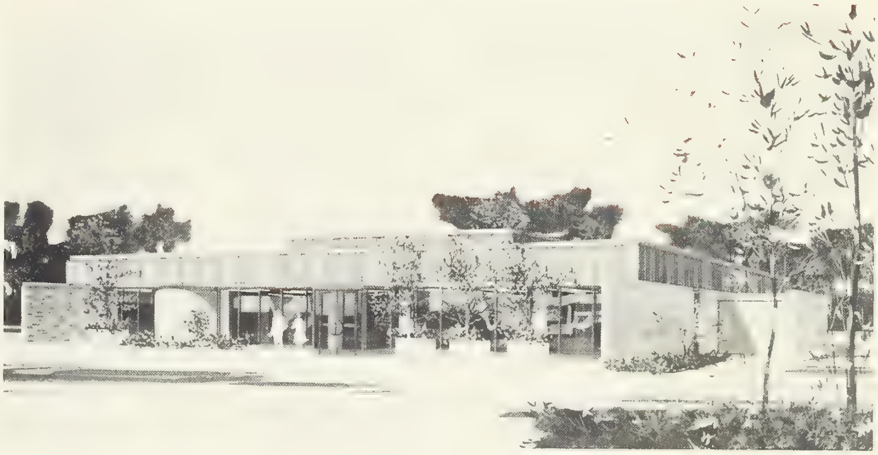
ESTABLISHED MEDICAL FACILITY available July 1. 1200 sq. ft. in Waterford, Drayton Plains area. Contact B. J. Jacks, DDS, 6021 Williams Lake Road, Drayton Plains, MI 48020, 313/623-7722.

HANCOCK HOUGHTON AREA — Office space is available immediately for interested physicians, 2300 sq. ft. in a 6 yr old building with 50 space parking lot with utilities and janitorial service included, office has own lab, emergency room and waiting room. Located 4 blocks from Portage View Hospital in Hancock. Contact Paul G. Goodreau, MD, 906/482-1839 or Leonard Beesley, DDS, 906/482-8602, at 1111 Hecla Street, Hancock, MI 49930.

MEDICAL AND DENTAL OFFICE under construction — Tremendous growth location, 16 Mile just east of Ryan Road, Sterling Heights. Available soon. Call B. Monast at 313/542-7100.

OFFICE SPACE FOR LEASE between 14 and 15 Mile Road on Utica Road, Fraser. Summer of 1979. Next to golf course, airport. Across from hockey, racquet ball and tennis complex. Near St. Joseph West and South Macomb hospitals. 313/772-5070, 313/286-5757.

LOANS TO PROFESSIONALS — Loans now available to physicians and physicians-in-training. Consolidate debts or any purpose loans. Also loans to executives. Loans to $50,000 or more — unsecured — no collateral necessary. Also second mortgages available to $25,000 or more. For information call A. Clayton Rieder, Financial Consultant, 80 Circle Drive, Syosset, NY 11791. Tel: 516/935-1234.



The Warren Surgical Center

First Michigan surgi-center being built

The first surgi-center in Michigan, an outpatient facility designed to reduce medical costs, is under construction in Warren.

The Warren Surgical Center is headed by Stuart W. Hamburger, MD, chairman of the board, and Paul T. Lahti, MD, president. They predict savings of one-third to one-fourth per operation, or $4 to $5 million per year for the center.

Doctor Hamburger also is Chief — Service 1, senior attending surgeon at Sinai Hospital in northwest Detroit. Doctor Lahti is senior attending surgeon at William Beaumont Hospital in Royal Oak.

Examples of operations that can be performed by the patient's own surgeon in the center include breast tumors, tonsillectomies, hernia repairs, cataract removals, varicose vein surgery, setting of broken bones, and much plastic surgery.

Although this type of center is new to Michigan, there are 70 in operation successfully in the United States. Plans are for the Warren Surgical Center to open in October.

Doctor Lahti wrote the first article on the subject to appear in a medical journal, "Early Post Operative Discharge from the Hospital," in *Surgery*, March, 1968. It helped pave the way for the first ambulatory surgical center to be built in this country, in Phoenix in 1970.

President's page

Get off our backs!

Louis E. Heideman, MD
MSMS president

It is time the FTC, HEW, the unions and industry get off the backs of the medical profession so that we can effectively participate in the continuing improvement of the health of the people.

We have been under continuing and unreasonable attack for a number of decades now. The attacks have included imposition of undue regulatory requirements which waste physician time needed for patient care at the very time that one of the national complaints was a shortage of physicians.

We are criticized for excessive utilization of resources after contracts have been negotiated which call for more health service. Review and regulatory requirements are imposed which raise the standard of care and increase utilization.

We are barred from participation in control mechanisms and health planning, and then criticized because the new systems don't work. We are criticized as having generated a shortage of physicians and are now blamed for the expansion of our medical schools and the cost implications. Yet HEW doesn't really seem to know or understand how the health care service works or what the effective economics are.

HEW bases its projections of the future on past performance without factoring-in appropriate modifiers or the incorporation of new and predictable changes in technology. It seems to be attempting to apply industrial methods without testing the appropriateness of the model or recognizing the very great variability among human beings and their individual needs.

Contradictions distressing

The most distressing thing is that contradictory signals are being presented by different governmental agencies. The HEW seems to want fixed fees; FTC finds any discussion of this anticompetitive, against the best interests of the "consumer," and representing a conspiracy to fix prices. The latter agency is demanding that the medical profession do more to control costs,but it is proposed in the AMA-Connecticut state decision of the FTC that we be prohibited from talking to anybody about anything that has any possible economic impact. The entire consumer movement seems designed to promote egalitarianism when it becomes more and more evident that about the only way human beings are equal is the inherent right to respect as a human being.

It is inevitable that our experiences color our world and that we think what we do is right. This explains the approach of the unions and of industry to the introduction of systems to health care delivery. There is room for systems, and there are systems currently operative. But these parties are not familiar with the current systems, and so say health service is a non-system.

It is demanded that health care delivery be broken down into components that can be delivered by individuals with little or no training under the supervision of the physician, without realizing that the major impact of this approach will be to increase costs and to reduce patient satisfaction and efficiency.

Give us room

This changes the organization for health care delivery without any change in the fundamental process and is analogous to the change from cottage industry to the assembly line. It changes the physician from a provider of health care to a manager of care, which is not what people want. One of the most common complaints we hear is that the physician today does not spend enough time with the patient.

I could go on and on in the same vein. There are things to criticize in the medical profession and health care service. But these complaints apply to a very small segment and are not the mode, as the proponents of change would have us believe.

Give us some room so that we can address these problems, instead of the current pressures on the profession which approach outright harrassment.

We have the will, the skill, and the knowledge to identify what is wrong and the intelligence to develop effective remediation instead of the half-baked ideas being proposed by the economists, the planners, the politicians and the self-appointed consumer spokespeople.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Her next attack of cysti

the Bactrim™ 3-system counterattack

ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

CAPSULES

THE MICHIGAN PHYSICIANS MUTUAL
LIABILITY COMPANY announces a
five percent rate decrease
effective July 1. The decrease
vill be coupled with a simpli-
fied application procedure,
vhich will be in effect for a
limited time. Watch for de-
tails in a coming Medigram.

* * *

ISMS MEMBERS, DID YOU take
careful note of the many
special features of recent
issues of Medigram and Michi-
gan Medicine? The April 23
Medigram contained a 1979
file folder for CME record-
keeping, as well as up-to-
late information on CME rules,
egulations and legislation.
he May issue of the journal
ontains a special section on
he MSMS/Physicians Service
roup which is expanding mem-
er services, including finan-
ial counseling and practice
anagement seminars. And the
ay 14 Medigram summarized
he MSMS House of Delegates
ctions of May 4-6. It also
ncluded a special report on
ey Michigan medical legisla-
ion, including the MSMS po-
ition on the bills.

* * *

SMS MEMBERS ARE URGED to
ake great care in handling
nd using pads of prescription
lanks. Carl Cross, executive
ecretary, Board of Pharmacy,
as informed the Board of Med-
cine of an alarming increase
n diversion of drugs due to
heft of prescription blanks.
Most of these thefts occur
ue to negligence on the part
f the health professionals
nd their staffs," says Mr.
ross. Sophisticated forgers
ultiply the problem, he adds.
Prescription blanks should be
ept secure and away from open
reas."

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 15 MAY 25, 1979

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Fee regulation posed in new BCBSM bill

Authority to regulate rates and fees paid to providers would go to the insurance commissioner in a new amalgamation of four bills offered in the Legislature to restructure the Blue Cross/Blue Shield of Michigan board and organization.

The bill, which probably will be numbered HB4555, proposes to empower the insurance commissioner to approve or disapprove rates of reimbursement to providers. It means that prior approval by the state would be required before physicians' fees could be paid! The commissioner would also have the power to arbitrarily impose cost containment regulations on physicians, hospitals and other providers through third party payors. Further, the bill provides that "interested parties," including the attorney general and consumer groups, could intervene in hearings called to resolve disputed decisions of the commissioner; that is, if an MD chooses to exercise his/her right of appeal of a decision to regulate fees, these other groups could enter the dispute to argue the issue.

W. E. Maldonado, MD, Chairman, MSMS Committee on State Legislation and Regulations, terms the bill "the most important to doctors since the malpractice crisis of 1975. Perhaps it is even more important, for it could allow the state to exercise total control over health care. We must not allow this to happen."

The bill now is under consideration by the House Insurance Committee. Its members are Reps. Matthew McNeely, Detroit, Chairman; Richard Fitzpatrick, Battle Creek; John Bennett, Redford; Mary Brown, Kalamazoo; Dennis Dutko, Warren; John Maynard, St. Clair Shores; Casmer Ogonowski, Detroit; Jelt Sietsema, Grand Rapids; Virgil Smith, Detroit; Robert Welborn, Kalamazoo; Michael Busch, Saginaw; James Hadden, Adrian; Charles Mueller, Linden, and Donald VanSingel, Grant.

Telephone your legislator! Tell him what you think of the new HB4555. If possible, meet your legislator personally and explain the dangers of rate regulation--of a health "czar." Write to the governor. The time has come for individual doctors to fight against Michigan's own version of national health insurance.

MICHIGAN PHYSICIANS INVOLVED in health planning activities are invited to confer with top level health planners at the AMA's Midwest Regional Health Planning Workshop June 15-16 at the Hyatt Regency O'Hare (Chicago). Dennis Paradis, director, MSMS/HSA Physician Support Center, will moderate a panel on Saturday morning, June 16, on "Rural Health Planning: Positive Potential." Interested physicians may contact Mr. Paradis for further information at 517/337-1351.

* * *

TWO MICHIGAN PHYSICIANS are members of the New Health Occupations Council, appointed by the governor. They are Mary L. Cretens, MD, Gladstone one of two health care administrator members on the 28-member board, and J. William Hayden, MD, Allegan, one of 12 professional members. The other 14 are public members. The Council is to provide a coordinating mechanism to regulate health occupations and was created in accordance with the new Public Health Code.

* * *

JOHN M. MALONE, MD, Farmington Hills, is in his second term as chairman of the MSMS Judicial Commission. He was reelected at a recent Commission meeting. New vice-chairman is William C. Baum, MD, Holland.

Plan now to attend MSMS seminars on personal and practice finances

Two of the three Personal and Practice Financial Planning Seminars to be conducted in June by MSMS's Physician Service Group still have openings. A third seminar has been cancelled. Interested doctors shou contact John Anthony at MSMS, 517/337-1351, immediat- ly to reserve spaces at these workshops. A maximum 50 physicians will be enrolled in each session.

The seminars will cover a wide range of financial questions, including arranging financial priorities, when to incorporate, computerization, wills and esta planning, and many others. Spouses are encouraged t accompany attendees.

The seminars will be held Wednesday, June 13, in Lansing and Thursday, June 14, in Southfield. The session originally scheduled for June 15 in Detroit has been cancelled. Registration is $95 for MSMS members, $115 for nonmembers and $45 for spouses of attendees. Lunch is included.

Don't miss this chance to gain a full perspective on your finances!

MSMS watching Medicaid funding

The MSMS Medicaid Liasion Committee, headed by David Siegel, MD, Lansing, is keeping a close watch on the legislature's activities to develop Medicaid cost containment measures. A joint House/Senate task for has been established to develop cost suggestions by the end of May. The Management and Budget and Socia Services directors have predicted a need to reduce spending in the current and next fiscal years by abo $150 million. The situation has been confused by House Speaker Bobby Crim's recent claims that inflation will both cause shortfalls and more than make u for those shortfalls.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 78 No. 15, May 25, 1979

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Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram

VOL. 78, NO. 16 JUNE 8, 1979

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MICHIGAN PHYSICIANS SHOULD APPLY by July 4 to MSMS for new positions opening on the Board of Medicine in December. Five of the six openings will be for physicians. Further information is available from Gary Anderson at MSMS headquarters.

* * *

REGULATION OF REIMBURSEMENTS to doctors through BC/BSM is proposed in legislation to reform Blue Cross & Blue Shield of Michigan. The proposal would give the insurance commissioner prior approval of reimbursement contracts. See accompanying report on back page of this Medigram. Write, call, wire your state legislators with your views.

* * *

MSMS WILL TESTIFY SOON on a proposed bill to prohibit state funding of abortions performed for Medicaid recipients. The fourth of five hearings scheduled by the Senate Committee on Health and Social Services is to take up medical aspects of abortions.

The Medicaid funding of abortions continues to arouse controversy. As this issue went to press, the attorney general was expected to seek a stay of a circuit court ruling that declared state funds can only be used for medically necessary abortions, and not for elective abortions. MSMS has supported the state funding of all abortions according to a 1978 MSMS House of Delegates resolution on the principle that all persons should have equal access to all medical care.

MSMS awaiting consent order; FTC's wording uncertain

As this Medigram was going to press, MSMS leaders were awaiting word on the final form of a proposed consent order which the Federal Trade Commission wants MSMS to sign. The consent order was expected to require MSMS to cease any negotiations with third party payors, including Blue Cross/ Blue Shield of Michigan.

On May 31 MSMS Director Warren F. Tryloff, Legal Counselors A. Stewart Kerr and John L. Shoemaker, and Washington legal consultants met with the deputy director of the Bureau of Competition of the FTC, to present a restatement of the MSMS position and seek an "air of reasonableness" in the discussions regarding final language of the consent order.

The meeting was helpful, reported Louis R. Zako, MD, chairman, to the MSMS Council. The FTC deputy director did agree to defer submitting the proposed complaint and consent order to the commission until June 5 so that he could review the specific arguments for change from MSMS. A letter describing the MSMS position was dispatched June 4 and hand delivered for the FTC deputy director's review on June 5.

The order may be issued without change, reported Doctor Zako, or the FTC deputy director might be willing to accept some change before submitting the order to the members of the commission, after which a formal complaint may be issued.

Even though the complaint is issued, the deputy director assured Mr. Kerr that further negotiations with the FTC are still possible, Doctor Zako continued. However, if MSMS declines to sign the consent order, there will be formal hearings before an administrative law judge followed by an appeal before the full commission and then it would be on to the federal courts--a decision yet to be made.

"At such time that Mr. Kerr advises us that further negotiation with the FTC is no longer possible, I will call upon The Council to make a decision as to our next course of action," said Doctor Zako.

CHANGE IS ONE of the great, inevitable forces in life. The MSMS Physicians Service Group, Inc., suggests you take a few seconds now to think about the effect of change on your will. When you had it drawn, you may have said, "There's a good job well done. Now I can forget that!" The first part of your reaction was sound; it was a good job completed. Everyone with property to dispose of and a family to provide for should have a legally-made will. But the second thought, "Now I can forget it," was full of danger.

As PSG points out, change is at work all the time. Your plans of a year ago may not be your plans of today. Values have changed, your property might be different, there may have been changes in your family, or changes in your ideas. Bring that will up to date! For assistance in estate planning, please call or write:

Robert T. Stanziano,
Director of Financial
Services, MSMS/Physician
Service Group, Inc.,
PO Box 950, East Lansing,
48823, 517/337-1351.

Doctor Zako: Proposed BCBSM char create arena for health care takeove

In an effort to reform Blue Cross/Blue Shield of Michigan, writers of proposed legislation have gon far beyond their original intentions. They have created the arena for a total take-over by the state of the health care system. So testified Louis R. Zako, MD, MSMS Council chairman, May 30 before a special subcommittee of the House Insurance Committee. Doctor Zako's testimony was the most recent action by MSMS in response to the proposed legislation. Four bills which seek the restructuring of the BCBSM board are being combined into one which also proposes to empower the insurance commissioner to approve or disapprov rates of reimbursement to providers.

"The position of the MSMS is clear," said Doctor Zako. "We concur with your desires to reform Blue Cross and Blue Shield; we oppose excessive regulation of providers through the office of the insurance commissioner.

MDs' triennial relicensure proposed

The Joint Rules Committee of the Michigan House and Senate will consider a proposal for triennial relicensure of physicians at a hearing June 19 in Lansing. The proposal is being made by the Health Services Bureau of the Department of Licensing and Regulation.

MSMS offered testimony in support of triennial licensing after the proposal was introduced in December. MSMS believes triennial licensing would coordinate well with the already established three-year CME cycle. MSMS is continuing to follow the progress of these proposed rules and will keep the membership informed through Medigram.

Michigan State Medical Society
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Year of the Child

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Michigan Medicine

JUNE 1979 • VOLUME 78, NUMBER 17
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Contents

June 1979

Michigan Medicine

Michigan Medicine

The well-being of children is the topic in the International Year of the Child, the theme of this month's special section beginning on the facing page. The cover is of Kristin Atman, 2, Holland, niece of MSMS Communications Bureau Chief Mert Scholten, who took the photo.

Special Section

287 **It's the International Year of the Child, and Michigan physicians have many opportunities for involvement;** John M. Dorsey, Jr., MD; Nancy Perkin; Paul J. Hletko, MD, and Jana D. Hletko; Natalia M. Tanner, MD

Features

292 **Adolescent immunization schedule**

294 **Ronald McDonald House;** Shelton Reece

325 **Two weeks caring for the Navajo;** Orville Oughtred, MD

328 **Mackinac Island rotation;** Robert Vanden Berg, MD

331 **"Alpha-omega" courses a feature of 1979 MSMS Annual Scientific Meeting**

336 **Rep. Bryant, House Minority Leader;** Willah Weddon

340 **Can you identify this body? Jackson State Police ask**

345 **Complete list of MSMS committee members**

Departments

296 **MSMS/A; The IYC;** Anita Yannitelli

298 **MSMS Q/A**

300 **Medico-legal; Countersuits**

301 **Letters**

305 **Views;** Paul T. Werner, MD, and Thomas E. Zerbel; Albert W. Sparrow, MD; Elmer W. White

314 **Welcome; New MSMS members**

318 **News**

330 **Meetings; of MSMS, AMA, other organizations**

344 **Ad index**

338 **Business**

350 **Category I courses**

354 **Deaths**

356 **Classified ads**

358 **President's Page;** Ernest P. Griffin Jr., MD

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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International Year of the Child prime opportunity for Michigan MDs

By John M. Dorsey, Jr., MD
Birmingham

People look to physicians to "speak up for children."

In this International Year of the Child, it is particularly important that members of our medical society become involved in this most important commitment.

Children's rights

The International Year of the Child has been declared by the UN General Assembly on the 20th anniversary of the UN's endorsement of the following Declaration of the Rights of the Child:

The right to affection, love and understanding
The right to adequate nutrition and medical care
The right to free education
The right to full opportunity for play and recreation
The right to name and nationality
The right to special care, if handicapped
The right to be among the first to receive relief in times of disaster
The right to be a useful member of society, and to develop individual abilities
The right to be brought up in a spirit of peace and universal brotherhood
The right to enjoy these rights regardless of race, color, sex, religion, national or social origin.

We Michigan physicians need to show where we stand this year in this international effort. We can pick our own areas of interest.

The goal of the IYC effort, promoted by the UN General Assembly, is promotion, publicity and legislation, when indicated, for the legitimate needs of our children, and the support of any worthy program rising from these needs.

Each UN member nation is involved in this year-long push, and is outlining its own priorities.

Here in the United States, the US National Commission on the IYC reports to President Carter about plans, programs, dialogues and pertinent legislation arising from each state's efforts. The commission has considered these as priorities:

Child nurturing, health and education; juvenile justice; development through recreation, play and the cultural arts; equal opportunity; cultural diversity and the impact of media on children.

Michigan activities

The Michigan Academy of Pediatrics, in conjunction with the American Academy's 50th Anniversary in 1980, is active in radio, TV, newspaper publicity and campaigning for accident prevention programs, especially in automobile safety. (Paul D. Hletko, MD, Kalamazoo pediatrician, provides information on children's car seat restraints in an article in this section.)

Legislation has been introduced by Sen. John Kelly (D), Detroit, to provide tax credits for the cost of infant and child automobile restraints, as a medical expense.

Future legislation for compulsory use of such restraints for children up to 40 pounds is being considered. Instruction sheets are available, free, asking parents to take their newborns home in a safety carrier.

The American Academy of Pediatrics also has launched a national goal, in conjunction with the IYC, for 90 percent immunization of America's children by 1980. The American Medical Association has pledged its full support to the AAP's program. (Please see the article by Natalia Tanner, MD, Detroit, in this special section for the Michigan efforts in this area.)

The American Academy of Pediatrics has taken the phrase "speak up for children" as its anniversary theme.

The Michigan Chapter's Comprehensive Child Health Plan, written to represent what the chapter views as priorities for children in any health planning activity, is described in an article featured in this special section.

The National PTA and its Michigan Chapter are evaluating new methods and approaches to health education in schools.

The National League for Nursing is active in its childhood immunization project in 1979. The National Nutrition Consortium and 200 other national organizations, many with Michigan chapters, have volunteered their services to the IYC.

MD involvement

The Citizens for IYC is Michigan's only grass roots organization. It is made up of people who don't belong to other organizations. It needs money, encouragement and more members to spread the message of the IYC across the state. Inquiries about this group can be made with Diana Thottungal at (313) 352-3194.

There are not enough physicians involved in child advocacy except by broad, nonspecific endorsement. But now any physician can obtain an AAP poster with the official "speak up for children" message on it, put it in the office and allow patients to ask about it.

The main goal should be to find out what patients think their children or other children need in order to improve our American quality of life.

(Please see other sections of this issue for articles pertinent to the International Year of the Child concerns.)

Doctor Dorsey is medical subcommittee chairman of the Michigan Citizens for IYC. He is in private pediatric practice and on the staff of William Beaumont Hospital, Royal Oak.

MCAAP position paper declares health planning must not fragment child care

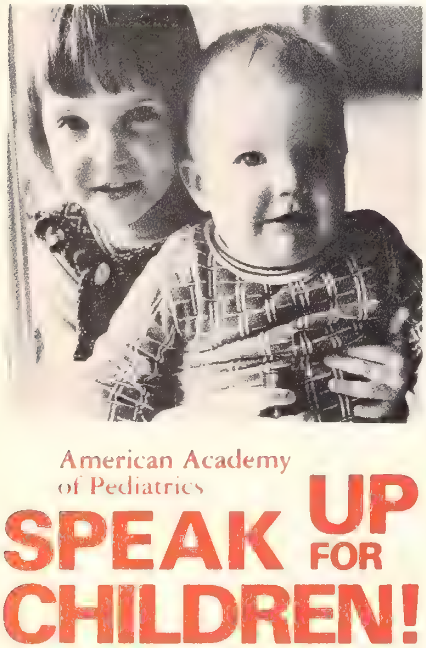
By Nancy Perkin
Special to **Michigan Medicine**

"Child advocacy" is an idea that few would dispute. Everyone is "for children"; no one "against them."

And yet, some physicians in Michigan and elsewhere believe children have long been neglected through failure to recognize and plan for their specific health needs.

The 20,000 members of the American Academy of Pediatrics have set out to do something about it.

Most recently, in response to deficiencies seen in PL 93-641, the Health Planning Resources Act of 1974, the association began activating its state chapters, regional divisions and office for governmental liaison in Washington, DC, toward its primary goal; to respond directly to state and local health planning agencies in an attempt to point out the urgent need for child health planning.



A step forward

As part of this commitment, the Michigan Chapter — American Academy of Pediatrics has formulated a plan of nearly 200 pages entitled "A Comprehensive Health Care Plan for Children in Michigan: Preliminary Documentation and Analysis."

The good works of two Michigan physicians are primarily responsible for completion of the task. Sparked by AAP headquarters in March 1977, William C. Montgomery, MD, chief of pediatrics at Detroit's Mt. Carmel Mercy Hospital and 1977-78 chairman of the MCAAP, compiled ideas for a Michigan plan flexible enough that each of the state's eight health service areas could adapt it to local needs.

Doctor Montgomery was succeeded in the Michigan chairmanship in July 1977 by Robert Holm, MD, of Blodgett Memorial Hospital in Grand Rapids, who actually wrote the plan.

He was assisted by a health administrator who collected data; the AAP executive committee, physician-leaders of the state medical schools, officers of component pediatric societies and a cross-section of urban and rural pediatricians in the state.

The Michigan Child Health Plan, begun as a labor of love and commitment in March 1977, was completed in September 1978, only 18 months later.

Children's health separate

In his prologue to the MCAAP plan, Doctor Holm summarizes the group's philosophy: "Children have health problems quite separate from adults, and since the maintenance of good health in childhood is essential to lifelong health and intelligent health care behavior, we feel that planning for children should have high priority in the development of overall plans."

Subsequent chapters examine the current state of child health care in Michigan; major threats to child health in the state and, finally, the regional goals thought to be important by the MCAAP. Included in the report are detailed diagrams and tables outlining accessibility of services, distribution of physician manpower, population profiles, and morbidity and mortality rates.

Plan won't fragment

A basic theme recurs: A truly effective plan must not fragment care of the child. As stated in the prologue, ". . . factors outside the health care system profoundly influence the health status of children and profoundly interfere with delivery of health care under the present system. Income, nutrition, housing, environmental factors, general and health education, racial and social discrimination and availability of transportation are all factors not susceptible to manipulation by the present health care delivery system.

"Failure to recognize these factors, especially as they relate to child health, and to plan objectives in these areas, will doom any health care planning to incomplete and inadequate improvement in health status of the target population . . . Objectives in these areas are not the primary charge of the HSAs at this time, but we encourage their inclusion since they exert an effect on health status as profound as any other factors. They currently represent the major obstacles to improvement of health status."

Physicians should instruct parents routinely on safety of children in and around autos

By Paul J. Hletko, MD, FAAP
Jana D. Hletko
Kalamazoo

For many years, the leading cause of pediatric mortality beyond the first year of life, lack of automotive safety, has been largely ignored in the physician's office.

Primarily through the efforts of groups such as Physicians for Automotive Safety, and Action for Child Transportation Safety, the importance of this area in preventive pediatrics recently has been brought to focus in the pediatric community.

For too long, the general public appeared to concede automotive injuries and fatalities as an unfortunate, but unavoidable, side effect of modern transportation. With the introduction, and subsequent wide availability of active restraint systems (seat belts and shoulder harnesses) in the 1960s, these attitudes appear to be changing slowly. This awareness is filtering to the pediatric age group as demonstrated by Tennessee's 1977 Child Restraint Law.

Restraint systems differ

Anatomic differences in the young pediatric patient necessitate unique restraint systems. An infant (from birth to 20 lbs.) should be transported in a rearward-facing shell-like device. When the baby can sit up very well and has outgrown the infant carrier, he/she should travel in one of the especially designed toddler seats.

Because children by nature have a very high center of gravity, simple seat belt usage is not adequate protection. A seat belt may ride high across the abdominal wall on a child less than 40 inches tall. This could endanger organs such as the spleen and liver. However, it should be noted that if a proper restraint is not available (e.g. taxi cabs), it is always better to use a regular seat belt than nothing.

When a child attains a height and weight of approximately 40 inches and 40 pounds, he/she can acceptably wear a standard seat belt. It may be necessary for the child to sit on a firm cushion (e.g. boat cushion) for proper fit and comfort. A shoulder harness may be added for children greater than 55 inches in height if the harness does not cross the child's neck.

Safe crash restraint systems are based on a single, or a combination of four, basic designs: 1) shell, 2) shield, 3) pedestal with five-point harness, 4) safety harness.

It is wise for the physician to be familiar with one or two representative seat systems from each category of devices to allow flexibility in selection of the system best suited for the family's automotive situation. It is also important to note that the manufacturers are now bringing out new models and changing model numbers at an ever-increasing speed, and understanding the principles of choosing a good, safe seat is important.

Other automotive safety

Passenger restraints are not the entire solution to this problem of automotive infant fatalities. There are other issues concerning automotive safety that seem obvious but deserve mention. Even if a child is properly restrained, it is imperative that all passengers in the vehicle be restrained. Other objects should also be carefully contained in the car. Station wagons present special hazards in this area, and use of proper storage compartments and a roof rack are very important. A family pet can serve not only as a projectile missile but also as a distraction to the driver.

Each year fatalities of children left unattended in a stationary vehicle are recorded. On hot summer days when extremely high temperatures can be reached in a locked car, heat exhaustion and thermal deaths have been reported under these circumstances. Unattended children can also set a vehicle in motion without much difficulty, causing injury to themselves as well as pedestrians.

Inadequate inspection of the area surrounding the vehicle before it is placed into motion is a frequent cause of injury and death to pediatric-age children. Any car backing down a driveway where children are playing presents special problems of awareness. This, like other points, seems obvious but never can be over-emphasized in the office.

Parents not only need to learn how to feed their children and how to immunize them against diseases, but equally as important, how to protect them in the automobile. This parent instruction and reminder should become part of regular office routine.

Doctor Hletko is chief of pediatric service at Borgess Hospital, Kalamazoo, where Ms. Hletko is consultant to the Pediatric Preventive Medicine Program.

Here are immunization responsibilities for practicing Michigan MDs

By Natalia M. Tanner, MD
Detroit

One of the major aspects of medical care is the prevention of communicable diseases, with the goal on increasing the total number of children adequately immunized.

To successfully complete this task requires consumerism by the patient, compliance by the parent, and expertise by the provider. The latter should have an awareness of current research developments of preventable childhood diseases and knowledge of the most recent recommendations for the administration of specific vaccines.

Measles an indicator

Recent national statistics reveal that in 1977, of 52 million children under 15 years of age, approximately 20 million were not adequately immunized. The epidemiological pattern of measles serves as an indicator of inadequate immunization trends.

The incidence of this disease with its serious complications of ear infections, hearing loss, pneumonia, and encephalitis has increased steadily since 1974. In September, 1977, the incidence was 55% higher than in the same period of 1976.

Michigan has had the highest incidence of measles in the United States since 1976. Michigan had 8,006 cases reported in 1978. On a national basis, measles has now moved toward a state of containment.

In an effort to rectify this grave problem and to resolve complacency which has accompanied the steadily increasing statistics regarding inadequate national immunization levels, HEW, on April 7, 1977, launched a major national campaign to immunize millions of our nation's children against vaccine preventable diseases. The National Immunization Initiative is a 34 month effort to increase public awareness, concern, and action regarding the low levels of childhood immunizations.

One of the most effective methods of increasing the total number of children immunized is the enforcement of our existing school exclusion laws. As of October, 1977, all states except Idaho and Wyoming had laws or regulations requiring immunizations prior to school entry. These laws have been most effective when it has been mandated that children be adequately immunized or face exclusion from school.

In Detroit, in 1977, 48 percent of children entering kindergarden were considered inadequately immunized. With enforcement of the school exclusion law, at the end of the year of grade one, 99 percent of these same school children were adequately immunized.

Some immunization guides

Private physicians are the source of immunizations for the largest percentage of children of our nation. The following are guidelines that health providers should be cognizant of:

1. There should be a careful assessment of each patient's immunization status upon entry into the health care system.

2. Health providers should be knowledgable concerning the recommended immunization schedule for children as proposed by the American Academy of Pediatrics, Committee on Infectious Diseases.

3. Recommended immunizations for adolescents should be carried out, because the greater percentage of this age group cannot document their previous medical record.

4. If a reliable history or documentation of immunizations cannot be obtained, the physician should presume the patient has been inadequately immunized, initiate vaccinations to rectify the deficiencies, map a plan with the family and utilize any support services that are available to enhance compliance.

5. The physician should keep adequate legible records of each patient's immunizations which can be readily retrieved.

6. Parents or the child's caretaker should be given a written record of the patient's up-to-date immunizations. The importance of this record should be stressed as a permanent health document.

7. Record reviews should be performed on an annual basis, and parents of patients who have not completed their immunizations must be notified.

8. Prompt responses should be given to requests from other providers and agencies for a transfer of copies of immunization records. Such requests need parental consent.

9. One should be cognizant of state laws and regulations regarding immunization requirements for the preschool-age child in nursery and day care facilitites.

10. Vaccines should be stored under adequate refrigeration until just prior to use. Sterile disposable syringes are recommended for each patient.

11. Physicians should be aware of immunization efforts of other community resources such as current school immunization programs and health department immunization clinics so that duplication of services can be avoided.

12. Health education should be an integral part of immunization responsibilities.

13. One should be aware that the American Academy of Pediatrics has a Task Force on Immunization Policy conducting a continuing study of possible compensation systems to reimburse patients who suffer vaccine-related injury through no fault of the procedure.

Please see table on adolescent immunizations, page 292.

Doctor Tanner is clinical associate professor, Wayne State University Department of Pediatrics, and regional coordinator, National Immunization Initiative.

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Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
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Immunization should not stop with childhood; This table shows requirements for adolescents

Table 3
IMMUNIZATION FOR ADOLESCENTS

Infectious disease	Immunization	Comments
Diphtheria/tetanus		
A. Patient completely immunized	Tetanus and diphtheria toxoid combined, adult type (TD); one dose 10 years after last booster dose and subsequently every 10 years. **Minor, clean wounds:** Booster dose if none in past 10 years. **All other wounds:** Booster dose if none in past 5 years. **Highly contaminated wounds:** Booster dose plus human tetanus immune globulin (Tlg), 250 units.	
B. Patient never or incompletely immunized	TD; 2 doses 6-8 weeks apart, booster in 8-12 months. **Minor, clean wounds:** TD dose and complete series. **All other wounds:** TD dose plus Tlg 250 units.	
Pertussis	**High-exposure risk or epidemic:** 0.2 ml. pertussis vaccine plus erythromycin 1-1.5 gm./day for 10 days.	Routine immunization not recommended for anyone over 6 years of age.
Poliomyelitis		
A. Patient completely immunized	No booster recommended by some; Booster at age 12 only recommended by others. **High-exposure risk:** Trivalent oral polio vaccine (TOPV), single dose. Or inactivated polio vaccine (IPV), single dose.	
B. Patient never or incompletely immunized	TOPV, two doses eight weeks apart, booster in 8-12 months. **Youths over 20:** Preferable to give IPV, 3 doses 1-2 months apart, fourth dose in 6-12 months.	
Measles	Single dose at any age if needed. Live, attenuated vaccine advisable for anyone immunized with killed vaccine or nonpotent live vaccine or who has been vaccinated before the age of 12 months.	
Mumps	Single dose at any age if needed.	Tests for immunity are unreliable or unavailable.
Rubella	Single dose at any age if needed. Advisable to vaccinate girls prior to menarche. Caution: For postmenarchal young women, vaccinate at end of normal menstrual period or in immediate postpartum period. Pregnancy should be avoided for three months postvaccination. Obtain serum for rubella titer before vaccination.	
Rabies	Human rabies immune globulin, 20 i.u./kg., half in wound, half IM.	
	Duck embryo vaccine (DEV), 1 ml. daily for 21 days; or, twice daily for 7 days and then daily for 7 days, with booster 10 days and 20 days subsequently.	**Patients allergic to DEV:** Request human diploid-cell vaccine and instructions from Center for Disease Control, Atlanta.
	Pre-exposure to rabies: DEV 1 ml. weekly for three weeks, booster in three months. Or 1 ml. twice, with doses one month apart and a booster in 6 months. **Continued exposure:** Booster every 2-3 years.	

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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REFER TO PDR

Families of seriously ill children will stay at McDonald House

By Shelton Reece
Special to **Michigan Medicine**

"A child responds to treatment more effectively if his or her family is at ease during medical care. The family can be made somewhat at ease by being with the child as much as possible and by participating in the patient's care.

"The Ronald McDonald House TM will make it possible for that to happen," says Jack H. Hertzler, MD. He is president of the group building the lodging facility for families of seriously ill children being treated at Children's Hospital of Michigan, Detroit.

The McDonald House is being built on land provided by Children's Hospital. When it is opened early next fall it will offer accommodations as a home-away-from-home for up to 20 families of children being treated at the hospital for cancer, leukemia and other serious illnesses.

It will help to end the hardships parents frequently encounter when they must commute long distances, stay in expensive lodgings, or sleep on hospital cots while their youngsters are undergoing treatment or tests.

Initiated by COSOM

One of a series being built near major pediatric hospitals throughout the country, the McDonald House has been initiated by members of Children's Oncology Services of Michigan (COSOM). The non-profit organization was formed in 1977 to build the house, and will administrate it on completion.

COSOM is composed primarily of parents of children who have been, or are being, treated for serious illnesses at Children's. Their insight is evident in the design of the house.

"Common rooms," which families can share as they exchange experiences and help each other resolve problems, will be provided.

"In the case of a desperately-ill child, a child with a critical disease or in critical condition because of major medical or surgical illness, the family needs compassion, consolation and a chance to commiserate with others in the same situation," explains Doctor Hertzler.

"By its very nature, the House places such people in close proximity and provides a facility where a number of parents can be assembled and talk over their problems and try to console one another.

"If these families can help themselves and others to overcome the fears, anxiety and depression brought about by having a child who is critically ill, this can be therapeutic to the young patient too."

Doctor Hertzler points out that children who do not have to be hospitalized but who must have daily treatment or a course of treatments are brought to the hospital from all parts of the state and from other distant areas.

"Once again, the House provides an ideal situation for these patients and their families by helping them to avoid hospitalization for the patient, and the cost and inconvenience caused when family members have to stay in a hotel or motel."

The cost of using Ronald McDonald House TM will be $5 per family each night. There will be no charge if the family is unable to pay.

Major contributors

The major contributor to the $800,000-$900,000 project has been Michigan McDonald restaurant owners and operators who have pledged $300,000 over a three-year period. Some of the others who are deeply involved with the project are members of COSOM, Children's Hospital, and the Detroit Lions.

The home will rely greatly on volunteer help for chores such as housekeeping, gardening and maintaining food and supplies.

Louis E. Heideman, MD, president of MSMS, director of Adolescence Ambulatory Services at Children's Hospital, and associate professor of pediatrics, Wayne State University School of Medicine, comments "This is a most interesting and commendable project providing the opportunity to implement some of the new awareness and concerns for the child and the parents during the stress of illness.

"We have long been aware of the importance of paying attention to the psychological as well as physical needs of our patients. This is another step toward achieving the union."

COSOM welcomes contributions of money, which are tax deductible, of construction materials and/or furnishings for the home. Correspondence may be sent to Ronald McDonald HouseTM, Children's Oncology Services of Michigan, Inc., 3901 Beaubien Blvd., Detroit, 48201.

Jack Hertzler, MD, left and Detroit Lions linebacker Ed O'Neil talk with Shannon Williams, patient at Children's Hospital of Michigan, about new Ronald McDonald House.

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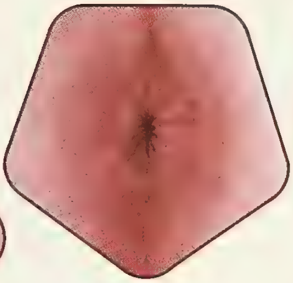
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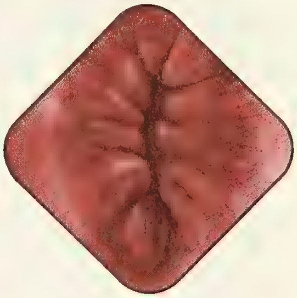
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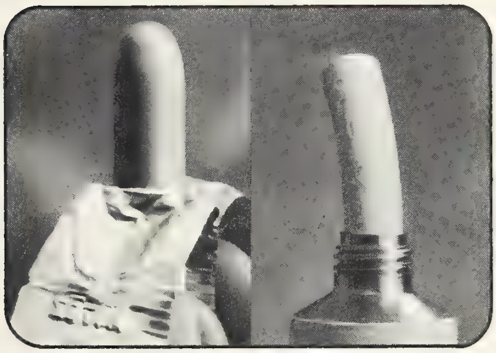
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Anusol-HC Cream is also indicated for pruritus ani

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The professional source of anorectal comfort

MSMS Auxilians working to end auto accident deaths and injuries to children

By Anita Yannitelli
Battle Creek

One program of the MSMS Auxiliary which benefits children is the Child Passenger Safety Project. The impetus for the project came from the State of Michigan Motor Vehicle Occupant Protection Program.

"1979 is the International Year of the Child and there is much that can be done to help children of Michigan. One vitally important area in which the efforts of medical auxilians can make a significant difference is the prevention of the trauma suffered by children while riding as passengers in motor vehicles," says Mrs. Edgar Calvelo, MSMS-A Highway Safety Chairman and president of the Jackson Child Passenger Safety Association.

Education tops

Education is the main thrust, according to Mrs. Calvelo, to educate parents, grandparents and the public-at-large of the need for proper restraints for children when they are passengers in cars. The auxiliary plans to do this through literature distribution and audio visual presentations at prenatal classes, PTAs, malls, doctors' offices and hospitals.

The auxiliary is also working with auto dealers. The dealers have been encouraged to display safe child seats in showrooms and instruct buyers in their proper use.

Auxilians are trying to encourage merchants to stop selling the unsafe seats. There are many unsafe brands on the market, she said. Of the safe seats, she said, up to ¾ of them are used incorrectly, which can be more dangerous than not using them at all. In the future auxiliary members hope to work with insurance companies and encourage them to perhaps get involved.

The MSMS-A will encourage Child Passenger Safety legislation, and hopes to encourage availability of rental seats for minimal cost both for parents and short term for grandparents and others who may have charge of children for a brief time.

On the local level, Mrs. Calvelo helped organize in Jackson County the first community meeting on child passenger safety in the state. It was jointly sponsored by the Jackson County Medical Society Auxiliary and the Michigan Office of Highway Safety Planning.

At a second meeting one month later, a "Jackson Child Passenger Safety Association" won unanimous approval. The members of the new association adopted the following as their statement of purpose:

"To ensure the right of every child to protection from injury or death while being transported as a passenger in a motor vehicle."

National model

The Jackson plan has become a model for the nation.

"The Jackson Child Passenger Safety Association serves as an outstanding example for communities in Michigan and all other states of how people who care about children can 'make a difference' by coming together and sharing their ideas and resources. The membership of the MSMS-A will move us quickly to the day when death and injury of children in cars will be an almost unheard-of event," says David Shinn, a representative from the Michigan Motor Vehicle Occupant Protection Program.

Mrs. Calvelo remarks, "There has to be a community, grass roots effort to set up the plan for action in Child Passenger Safety. Safe transportation of children is our first objective. The plan takes time organizing and has to be individually tailored in each community.

"People want to help and know the facts. We must first educate them about how to become effectively involved. The more groups committed to the welfare of kids, the surer we will be that we will eventually conquer the problem."

Mrs. Yannitelli is editor of the MSMS/A newsletter, The Auxilium.

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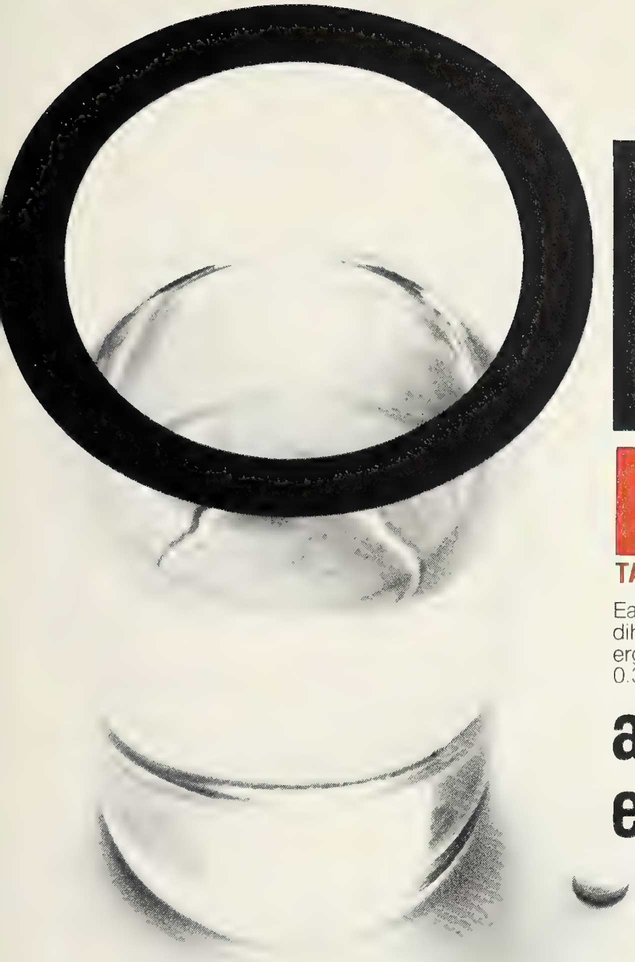

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MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

FOR: Harry Rosen, JD, senior legislative attorney
AMA Legislative Department

"I'm a practicing physician in Michigan. I am very interested in an issue currently under discussion at hearings in Washington. I would like to testify. Will you please tell me how I go about arranging to testify?"

If you want to testify at a hearing you must contact the committee which is conducting the hearing and ask to appear. The committee will want to know who you are, who you represent, what your qualifications are, and what will be the general meaning of your testimony. Unless you represent a relevant organization, are an individual of national renown or have exceptional knowledge and qualifications in the area that is the subject of the hearings, there is little possibility you will be invited to testify. The committee is more likely to ask that you submit your statement in writing and will assure you it will be considered at the time the committee reviews and considers the other testimony it has received.

Doctor Malone

FOR: John M. Malone, MD, Farmington Hills
Chairman, MSMS Judicial Commission

"If a patient asks to be referred to another physician, is it the family physician's obligation to refer? If the family physician refuses, what recourse does the patient have? Can the patient sue? Are there legitimate reasons for which the family physician might refuse to refer?"

In my opinion, it is the family physician's obligation to refer a patient to another physician, if that patient so asks. I find it hard to believe that there could be any legitimate reasons for not referring a patient on. It always has been my understanding, and that of my colleagues on the Judicial Commission, that the patient has the right to be treated by whomever he or she wants, just as the physician has the right not to accept someone if he or she so wishes.

Should a family physician refuse to refer a patient on, I would suggest the patient contact the county medical society, local hospital medical staffs, neighbors, friends, church and community groups for further aid.

Mr. Kerr

FOR: A. Stewart Kerr
MSMS Legal Counsel

"Is the rule that the physicians must sign the Blue Cross/Blue Shield claim form statutory or something made up by the Blues?"

Other than the enabling legislation, there is nothing controlling the Blues' procedures other than Insurance Bureau dictates. There is no statutory authority for the specific signing requirements; I assume that as part of their certification agreement, physicians agree to certify performance of services. Of course, there is no requirement that physicians must participate with the Blues; that is the individual physician's choice.

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MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw
East Lansing, MI 48823

MSMS PHONE: 517/337-1351

Wrongfully sued physician has no recourse under present law, recent article claims

"Do not walk where angels fear to tread," cautions a fellow of the American College of Legal Medicine as he paints a mostly gloomy picture for physician contersuits in the February, 1979 issue of *Legal Aspects of Medical Practice.*

The article has been brought to the attention of *Michigan Medicine* by MSMS Legal Counsel A. Stewart Kerr, who calls it "a pretty good summary of the current countersuit situation."

Harold L. Hirsh, MD, JD, a member of the editorial board of the magazine, states, "Physicians should recognize that under the present status of American law, a wrongfully-sued physician has essentially no recourse.

"Most verdicts have gone against the countersuing physicians, either in the lower court or on appeal, as in the Berlin case."

Doctor Hirsh says the recent reversal by the Illinois Court of Appeals of Doctor Leonard Berlin's successful countersuit "should not be considered merely a simple overturning of a lower court decision by a higher court."

Doctor Hirsh says the Appeals Court's reversal has greater significance because Doctor Berlin's original victory had a tremendous impact on the physician countersuit movement.

"His case was the spearhead for other countersuits by physicians and legal fund organizations formed to assist allegedly aggrieved physicians in their pursuit of justice . . . He became a physician folk hero . . . "

Doctor Hirsh traces the history of physician countersuits in medical malpractice cases and lists the difficulties involved for physicians. These include the problems of proving the patient brought the suit maliciously, of proving the physician suffered as a result of an unbased medical malpractice suit, of getting lawyers to prosecute a countersuit or testify against another lawyer, and of creating a countersuit fund legally.

In addition, notes Doctor Hirsh, the HEW Malpractice Commission and insurance companies' data indicate unbased, frivolous, nonmeritorious suits by patients have had a negligible impact on the malpractice crisis.

"The threat of countersuits may deter a few unbased claims," writes Doctor Hirsh. "But because of the countersuit surge, lawyers are now bound to be prepared to show that their suits are not frivolous or spurious."

Doctor Hirsh's article appears on pages 29-31 of the magazine.

Lawsuit not allowed when patient's doctor loses staff privileges

Editor's note: MSMS Legal Counsel A. Stewart Kerr summarizes an interesting Michigan case for medical society members:

The physician of a woman in the Detroit area had lost his hospital staff privileges. The patient brought a lawsuit on the theory that she has a right to receive hospital care by a physician of her choice.

The Federal Court threw this case out, pointing out, among other things, that "the law in this circuit is well settled that no state action exists where a licensed physician is discharged by a private hospital from its staff," notwithstanding Hill-Burton funds and the existence of certain state regulations covering hospitals.

(*Weber v. Detroit Osteopathic Hospital,* DBA Riverside Osteopathic Hospital, DCED Mich. No. 7-72530.)

Physician should get spouse's consent in sterilizations

In Michigan, the physician should continue to obtain the informed consent of the spouse in sterilization procedures, as well as that of the patient.

That is the opinion of MSMS legal counsel in response to a question posed by an MSMS member.

"Although lower courts in some states appear to be ruling that such consent is not necessary," comments Legal Counsel A. Stewart Kerr, "in Michigan the law and courts have not waived the requirement."

The exceptions in Michigan would be in cases of emergency where life may be in danger, in which case the informed consent of the patient should suffice, Mr. Kerr continues.

"Without complicating the record," Mr. Kerr noted to the MSMS member who posed the question, "I'll note that special care needs to be taken in instances where husband and wife are clearly and permanently separated. We believe that in this case a 'reasonable effort' to contact the missing spouse is sufficient."

Letters

"(Joyce Symons) will find (PA system) works."

I read with interest Rep. Joyce Symon's comments as published in *Michigan Medicine*, March 1979 issue.

Her reservations about physician assistants are provocative although, I believe, lacking in substance.

In a 10-year search of court cases on behalf of the AMA, their legal counsel issued the following statement, "PAs probably hold the potential for being one of the best malpractice prevention tools available at the present time." This opinion was reiterated by Doctor Frederick L. Shoen of the American Academy of Family Physicians, "The utilization of a physician assistant cuts down the chance of errors leading to malpractice suits."

Also, I would direct Rep. Symons to find additional information on supervision of PAs in The Institute of Medicine's *A Manpower Policy for Primary Health Care*, May 1978. This report was prepared by the National Academy of Sciences and states, "A review of liability problems revealed that actual legal complaints of malpractice *do not* hinder physician assistant utilization."

I believe Rep. Symons' intentions in making comments for *Michigan Medicine* were good. I hope she will contact a physician assistant, or better yet, a physician who employs a PA for an honest appraisal of how the system works — she will find that too, working well.

Norman C. Holton, PA-C
President
Michigan Academy of
Physician Assistants
Lansing

Congratulations to emergency physicians

Editor's note: The following letter was sent recently from MSMS headquarters to George Podgorny, MD, President, American College of Emergency Physicians, Lansing.

I think the recognition of the work of the emergency physician by the creation of a specialty board is a most significant and appropriate step. Congratulations for your hard work in developing this, and to your continuing contributions to the health of our people.

Louis E. Heideman, MD
President, MSMS

Doctor Heideman's visit appreciated

The Huron County Medical Society appreciates the fact that Louis E. Heideman, MD, MSMS president, and his wife, accepted its invitation to attend and address the meeting of March 27, 1979. That the president of the Michigan State Medical Society would take the time and make the effort to attend a meeting of a relatively small county society is most heartening indeed.' (To the knowledge of all those present, it was the first time such had ever happened.)

C. C. Herrington, MD, Bad Axe
President, Huron County
Medical Society

"I would appreciate a sample folder . . . "

Thank you very much for the complimentary issue of the January issue of *Michigan Medicine*, and for the copies we will be receiving in the future. I look forward to getting it and see it as a helpful way of being more aware of MSMS' varied activities.

I was interested to note the information on AMA folders in the article on public service projects. I would appreciate it if you could send us a sample copy of the folder "When to Call or See Your Physician."

I am looking forward to future contacts.

Kirsten Kingdon
Executive Director
Area VII PSRO
Ann Arbor

Editor's note: Individual copies of the folder above, as well as others on being an intelligent patient, on arranging for a family physician, on medical care cost awareness, and on several medical conditions, are available free of charge from Mert Scholten at MSMS headquarters. Quantities are available at cost.

Young doctors seek group practice, quality hospital

Many young family physicians look for a community where they can join other family doctors in a small group practice.

That factor was mentioned most often in a study by the Michigan Health Council of questionnaires mailed in by 50 young doctors who are in specialty training programs in Michigan and Midwest hospitals.

Because young physicians come from many backgrounds and, like all people, have many different interests, there are many factors that influence why a physician selects a certain town for his practice.

Common comments

But the most common series of comments from doctors planning to be family physicians went like this:

"Ideally I want to practice with one or two more family physicians."

"Am looking for small partnership of 2-4 family physicians and also using a physical therapist, nutritionist and psychologist."

Would like to practice in partnership with 3-4 others but with good subspecialty coverage."

"Will join a group practice somewhere with good support services."

The strong interest in group practice also was expressed by pediatricians, internists, radiologists and neurosurgeons, according to Herbert A. Auer, executive vice president of the Michigan Health Council.

Quality hospital

The importance of a quality hospital was noted on almost every returned questionnaire. A young family physician in the Southfield Providence Hospital program said he "wanted a well-equipped general hospital relatively close to his future office."

There was considerable concern voiced by the young doctors in their search for a town with good schools, recreation and cultural activities. A future family doctor wrote from Milwaukee that he would look for "a town with good schools and a positive community spirit."

The Michigan Health Council operates the Physician Placement Service for the state and last year was helpful, to some degree, in "matching up" 79 physicians and communities, reports MHC Executive Auer.

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CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

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References: **1.** Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. **2.** Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977

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J-6999-4

April 1

Physicians need to understand role of hospice, integrate it in community

By Paul T. Werner, MD
Thomas E. Zerbel
Escanaba

The country's newly developing hospice programs for the terminally ill depend upon referral from the medical community for patient care services. Thus, it is imperative that members of the professional community understand the role of the hospice and work actively to integrate it into the total caring community in Michigan.

Physician involvement and understanding of hospice services are needed in all of the developing hospice programs.

Rich rewards of improved patient care, satisfactory symptom control, and resolution of grief and bereavement in the survivors will be the benefits physicians will receive.

Hundreds of hospice programs are emerging across the U.S. to care for terminally ill patients and their families.

In Michigan, these programs stretch from the greater metropolitan Detroit area to the rural reaches of the Upper Peninsula, and embrace the many different models that have been proposed for hospice care.

The hospice as a concept of care is hundreds of years old. It has been largely refined by the work of Dr. Cicely Saunders at St. Joseph's Hospice and St. Christopher's Hospice in London. From these germinal centers, representatives have spread across Europe and the United States.

Hundreds of communities have programs underway or in the planning stage. Teaching programs have been initiated by several of these hospices, and the National Hospice Organization operates from New Haven, Conn.

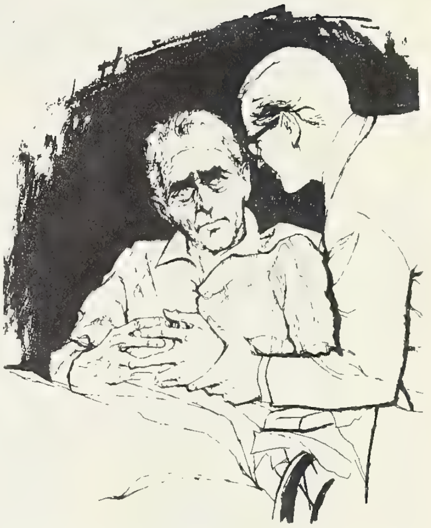
The third annual meeting of the National Hospice Organization occurred this past October in Washington, DC, and regional meetings of the organization took place in March of 1979. Michigan representatives were present at the national meeting in Washington, as well as the Midwest Region III meeting in Minneapolis in early March.

HEW has proposed a special hospice demonstration program. This program encourages hospice projects to apply for special exemptions from Medicare and Medicaid rules and regulations. It is the contention of hospice providers that their services for the terminally ill are less expensive than acute hospital stays for the same services. Three hospice programs in Michigan have applications pending for certification as demonstration projects.

Holistic care

Hospice care is aimed at the terminally ill patient and his or her family. The approach to the care is holistic, in that it deals wih the patient's spiritual, emotional, and mental needs, as well as the physical and economic aspects of dying.

The care team, in most settings, involves specialists from medicine, nursing, social services, and pastoral counseling, as well as generous input from volunteers.



The objective of the hospice is the relief of symptoms rather than the care of underlying disease. Patients accepted into the program have arrived at the end of benefits provided by traditional medical care.

Great emphasis is placed on pain control, with the use of oral mixtures of narcotics, phenothiazines, cocaine, and other ingredients known variously as Brompton's Cocktail or Hospice Mix.

Hospice teams have learned that once the tremendous psychological and physical burden of chronic pain is relieved, patients often become much more alert, cooperative, and responsive to their environment, enabling last-minute arrangements to be completed and the resolution of "unfinished business" between the patient, his family, friends, and others.

Most hospice programs are anxious to provide home care and take as one of their primary goals allowing patients to die in their own homes. Because symptoms are sometimes uncontrollable at home, most programs have some plan for inpatient services, as well. In all settings, the team approach is maintained.

Doctor Werner is an assistant professor of family practice in Michigan State University's Upper Peninsula Medical Education Program and a board member of Bay de Noc Hospice, Inc. Mr. Zerbel is a funeral director, educator and president of Bay de Noc Hospice, Inc.

Table 1: *HOSPICE GROUPS IN MICHIGAN*

Hospice of Flint, Inc.
806 West 6th Avenue
Flint, MI 48503

Hospice of Greater Grand Rapids
P.O. Box 1633
Grand Rapids, MI 49501

FISH Hospice of Oxford-Orion
715 North Lapeer Road
Lake Orion, MI 48035

Southwestern Michigan Hospice, Inc.
Tower 14, Suite 1180
21700 Northwestern Highway
Southfield, MI 48075

Wayne County General Hospital
Eloise, MI 48132

University Hospital Hospice Committee
University of Michigan Hospital
1405 East Ann Street
Ann Arbor, MI 48109

Munson Medical Center Hospice Program
Munson Hospital
Traverse City, MI 49684

Washtenaw United Way Hospice Planning Project
Washtenaw United Way
2301 Platt Road
Ann Arbor, MI 48104

Bay de Noc Hospice, Inc.
Suite 120, Doctors Park
Escanaba, MI 49829

Hospice of Lansing, Inc.
500 Northlawn
East Lansing, MI 48823

Hospice of Michigan, Inc.
73 Oakdale Boulevard
Pleasant Ridge, MI 48609

Hospice of Saginaw
Family Practice Center
1000 Houghton Street
Saginaw, MI 48602

Michigan Hospice Organization
c/o Representative David Hollister
House of Represenatatives
Lansing, MI 48909

Michigan hospices

Currently in Michigan, there are at least 12 programs actively pursuing hospice care.

To foster the development of these programs, and hospice care in general, a Michigan task force has been meeting since spring of 1976. State Rep. David Hollister convened a citizen's task force on death and dying. By January of 1978 this task force decided to investigate the hospice concept. A separate task force, developed to look into hospice care, holds regular meetings. Persons throughout the state are involved.

Most recently, this task force has incorporated as the Michian Hospice Organization. Its stated goals are to foster quality hospice programs and promote the hospice concept in Michigan. The organization will assist developing hospice programs, will seek to solve some of the problems that all hospice programs face, will investigate accreditation and license standards, and will serve as an umbrella and liaison group with other persons and interest groups throughout the nation and state.

In late March of 1979, a Michigan Hospice Developers Conference was held at Michigan State University. This brought together developing hospice groups from across the state. It identified a group of problems that hospices in Michigan are facing. Also discussed were needs assessments, feasibility studies, staff training programs, methods for mobilizing and educating the community, management of volunteer efforts, and legal and financial issues.

Challenges ahead

The goodwill and active enthusiasm of hospice organizers throughout the state undoubetly will surmount most of the current problems that hospice programs face.

The utilization of volunteers, the development of standards for hospice care, training of staff members, and the settling of insurance coverage issues for malpractice and liability will probably be resolved as hospice programs get underway.

A more difficult problem will be the method of payment for hospice services. Traditional third party coverage has not addressed care of dying patients outside the hospital. Also, bereavement care for survivors and payment for treatment of psychological and emotional symptoms by non-medical professionals are issues to be solved.

Another key issue is the proper integration of hospice services into the medical service community. The precise role of inpatient and home hospice care in relation to active oncology units, large metropolitan hospitals, and nursing homes still remains to be defined.

(More views on page 308)

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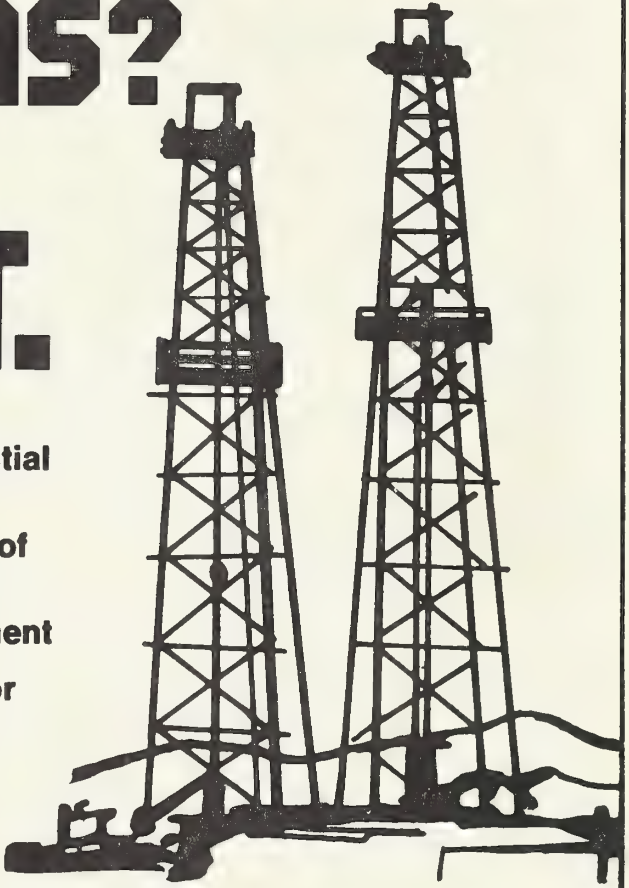

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Preventive approach needed to stem cardiovascular disease epidemic

By Albert W. Sparrow, MD
East Lansing

Atherosclerotic cardiovascular disease is the most serious threat to health most of us ever will face.

Today's average American male has a one-in-three chance of developing a major form of cardiovascular disease before he becomes 60. The average female has a one-in-six chance.

Thus we see the imminent need for preventive, protective action by all practicing physicians.

It is becoming increasingly evident that the intervention required must be preventive.

Nearly all the "action" in cardiovascular disease today revolves around dramatic innovations in treatment, including open heart surgery, bypass surgery, intensive care units, coronary care units and balloon pump assist devices. Diagnostic innovations are omnipresent, including very recent refinements such as echocardiography now available in two-plane-sector scanning devices.

At the same time, exercise studies, exercise electrocardiography, fitness models and community emphasis on exercise and physical activity are becoming more a way of life with the average American. It is only the latter which is in any way designed to be preventive or protective. And even this emphasis is today directed primarily at middle-aged early-older aged populations, most of whom have had their coronary event.

Doctor Sparrow is with the Department of Human Development, Michigan State University.

For measurable results we need to bring the knowledge of these threats to the younger population, reaching even into the formative and teenage years, where we are most likely to achieve some true protection or prevention. It is time that we who are interested and involved in the pediatric area of medicine, become activists and sellers of health awareness and availability of protective measures to our young population.

Only a preventive approach involving the diagnosis of presymptomatic disease and early management of predisposing factors well in advance of the clinical expression of the disease, can be expected to make a substantial impact in containing the progressive epidemic of cardiovascular disease.

The practicing physician can make a much larger impact on this cardiovascular disease epidemic than all the latest medical marvels combined, by using only ordinary office procedures, careful history data-gathering, simple screening laboratory tests, and promulgation of health maintenance and hygienic measures. The practicing physician must begin to realize and consider the importance of cardiovascular disease risk factors. Vulnerable persons must be considered well in advance of symptoms, in their early lives. Finally physicians must admit and realize the occurrence of overt symptomatic cardiovascular disease actually is a medical failure.

Our need is not only to identify within our practices individuals at elevated risk, but more importantly to recognize that in our American culture we are ALL at an elevated risk. Thus the institution of multiple preventive measures relative to diet, smoking, exercise, hygiene and behavior may better be thought of as a universal need in this country. If one waits for some preconceived, indicated level of "high risk" before instituting a preventive approach, part of the battle will already be lost. The encouragement of early prevention as a prudent objective for all Americans and particularly those in their teens and 20s will be much simpler and more productive than any corrective, preventive measures instituted once risk is already established. To achieve this we must intervene in the pediatric population by the use of sound, thoughtful counsel on weight and dietary habits, blood pressure, smoking activities, physical activities, serum lipid profiles, glucose tolerance, hypertension, personality types, stress and reaction to it.

Let us attempt to classify host and environmental contributors to cardiovascular disease, look at them as individual risk factors and project their consequences for each of the major cardiovascular diseases.

Atherogenic traits

Serum Cholesterol and Triglycerides: Within the range of values reported to physicians by clinical laboratories as "normal" cholesterol (i.e. 180-310 mg/dl), there is a five-fold range of risk relative to cholesterol. Thus the usual values encountered in the general population in the United States are far above optimal and an ideal cholesterol value is somewhere under 200 mg/dl.

A whole new range of normals must be considered when one considers the pediatric population. In the Muscatine Study evaluating nearly 5,000 children ages 6-18, approximately half male and half female, the mean serum cholesterol in all subjects was 182 mg/dl. Of note was the similarity of serum cholesterol levels at all ages, 6-18, for both boys and girls. Six-year-old children had a mean level of 171 mg/dl; 18-year-old subjects had a mean level of 177 mg/dl. There were few sex-related differences. The histogram of serum cholesterol levels for both boys and girls indicated that the lowest five percent of the children had serum cholesterol levels of 140 mg/dl and below and 24 percent of the children had levels of 200 mg/dl and above.

The striking finding then of the Muscatine Study was the large number of children who seemed to be already at risk for the development of coronary heart disease.

There are, however, no longitudinal data which relate childhood levels of serum lipids, or for that matter blood pressure and relative weight, to a later risk for atheromatous disease in adult life. Because there is a gradient of risk for these three variables, no one level clearly divides the population into normal and abnormal groups.

Thus it would seem appropriate to identify and consider at risk, children whose serum cholesterol concentration is at levels established in adults as predictive of the development of early occlusive atheromatous disease.

Only subsequent studies will indicate the relative permanence of serum cholesterol concentrations in children but even if only one-third have relatively fixed high values, this in itself will be a most significant number of children with a predictive factor identified early in life.

Blood pressure evaluation

It has been shown that systemic hypertension clearly accelerates the atherosclerotic process in populations with elevated serum cholesterol levels. There is no evidence, however, that systemic hypertension accelerates atherosclerosis alone or is associated with significant atherosclerosis in populations with serum cholesterol levels less than 200 mg/dl. Interestingly, systemic hypertension is the most frequent cardiovascular disease in the Black African. But atherosclerosis or complications of atherosclerosis are nearly nonexistent at this time in this population.

In the Muscatine Study nine percent of the 14-18 year group were shown to have systolic hypertension and 12 percent diastolic hypertension. If as estimates suggest, 20 percent of adults have levels of blood pressure placing them at risk and if childhood peer relationships of blood pressure follow into adult life, children with blood pressures greater than the 80th percentile for their age may eventually prove to be hypertensive adults. Only a long-term follow-up of children's blood pressures will establish what prediction of adult hypertension can be gained from childhood measurement of blood pressure.

Obesity as a risk factor

There is considerable preoccupation with obesity in affluent countries and both the afflicted and their physicians have long engaged in a fruitless and frustrating effort to correct it. The need to correct obesity and issues concerning the determinance of cardiovascular consequences of obesity have been and continue to be clouded by uncertainty, particularly about the validity of the methods for measuring obesity.

Although there is continued debate about how obesity is related to cardiovascular disease incidence and mortality, there are a number of well-documented associations of atherogenic phenomenon with fatness. Effects of obesity on angina and sudden death are fairly well accepted. However, its effects in cardiovascular morbidity are modest compared to other identified risk factors. The hazard of obesity further seems to wane with advancing age.

Other messages are more clear.

Obesity does not appear to be beneficial; reduction of weight has a significant impact on other risk characteristics; it is not possible to have a healthful self-image in the presence of obesity; a positive self-image is essential to the hygienic living pattern, and therefore prevention and reduction of overweight are important in the prevention of cardiovascular diseases.

What then can/should be done?

1. NO further major effort is needed to identify increased risk of Americans.

2. We need to develop better skills to motivate to change risk factors
— hygienic advice to all
— screening and intense intervention in the more vulnerable.

3. A public health approach will be the eventual model, when society so requests. This will require alteration of ecology and engineering of activity, diet, and use of tobacco.

These interventions NEED NOT be construed as invasions of freedom or privacy. There IS a pre-symptomatic stage of coronary artery disease; the disease IS avoidable; we are currently waging a losing battle against the complications of coronary artery disease. It is time to change our approach.

(References are available from the author.)

(More views on page 312)

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MDs' image depends 5% on media, 95% on doctor/patient relationship

By Elmer E. White
Special to **Michigan Medicine**

"It disturbs me," said a physician recently, "that so many people think doctors are bad because they think we keep patients from cancer cures and do not believe in vitamin miracles. These types of claims are especially frustrating against our background of a doctor-sponsored immunization program which has greatly diminished disease."

"Pathologists and radiologists take unconscionable amounts of money out of medical budgets — and sometimes set up competition to the hospitals where they work." "Doctors must police their own ranks more quickly and more effectively." "The field of psychiatry needs attention and disciplining from your profession." These were charges made by a newspaper editor who has also served on a hospital board of directors for some 30 years.

Mr. White, former executive director of the Michigan Press Association, is on retainer as a special media relations consultant to MSMS.

The comments above were part of the blunt, but polite, discussion which took place at a meeting of the Berrien County Medical Society during its program titled, "Why Doctors Get Bad Publicity."

William Bock, MD, and John Carter, MD, represented physicians in a panel discussion, while Frank Deaner, WSBT-TV in South Bend, and N.A. Lindenfeld, editor of the Herald-Palladium in Benton Harbor, presented views from MSMS media. Elmer E. White, consultant to MSMS, was moderator.

How media could improve

Physicians at the meeting charged that media do not report completely about many things, especially new medicines, and that stories about Laetrile are unclear and lack proper perspective. They resent unfounded, inaccurate charges about cost of doctors' services in the total medical expense of the nation. They feel that media people do not understand, nor make efforts to seek out, information about government regulations which make it expensive and clumsy sometimes to practice medicine.

Doctors on the panel tended to agree that all physicians should work harder to control costs and try to explain to patients and others why it is that doctors can provide better, more economical medical services than is possible under any National Health Insurance program.

Media people agreed that it is often hard to get definitive information from doctors within the time existing to disseminate news. They said they would welcome calls from the medical world to advise them of new equipment installed or for a rundown on how health services are functioning.

How MDs could improve

Mr. Lindenfeld suggested doctors place too much emphasis on media, and no one disagreed when he said that five percent of public relations depends on media and 95 percent depends on physician/patient relationships.

He encouraged doctors to think about how they could improve the latter, suggesting that they take a little more time to make each patient feel he has received personal, caring consideration. He urged doctors to review with staff the need to treat people politely, suggesting that office employees might be over worked or over protective of the doctor, but that this should not excuse them from failing to treat patients with courtesy.

Panel members expressed themselves at the end of the meeting as having a new appreciation of the position of those in the other group and a new understanding of how to work toward a common goal: providing accurate information to the public about medical matters. They agreed that by working more closely together, this goal would have a better chance of being realized.

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Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

(Multiple lists appear on these pages)

Harvey G. Ager, MD P
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Southfield, 48034

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3340 Hospital Rd.
Saginaw, 48603

Abu Q. A. Ahmad, MD OTO
121 Camelot Dr. #12
Saginaw, 48603

L. Lee Atrostic, MD OBG
2143 Sandy Shore Dr. #302
Grand Rapids, 49508

Eduardo V. Barlan, MD GS
9061 Aura St.
Kaleva, 49645

Calvin J. Bergsma, MD U
1560 E. Sherman #250
Muskegon, 49444

Jorge J. Carrillo, MD IM
Henry Ford Hosp.
Detroit, 48202

Ninfa D. Cayayan, MD GP
11454 Beaconsfield
Detroit, 48224

Maynard B. Chenoweth, MD
Dow Chemical Co. Bldg. 607
Midland, 48640

Joon Young Choi, MD CHP
7636 Allen Rd.
Allen Park, 48101

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2470 Teinken Rd.
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INDICATIONS: *Therapeutically,* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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News

Doctor Friedlaender

Doctor Pierce

Doctor Willis

Doctor Wright

New president of the Association of University Cardiologists is **Park W. Willis, III, MD.** Doctor Willis also is new professor of medicine and Director of the Division of Cardiology at the MSU College of Human Medicine. He previously served more than 26 years at the University of Michigan and was professor of medicine in the U-M Department of Internal Medicine prior to his move to MSU April 1.

Sidney Friedlaender, MD, Southfield, is recipient of the Distinguished Service Award of the American Academy of Allergy. The citation reads, in part, "Doctor Friedlaender . . . has represented the ideals and aspirations of the Academy throughout his career and most recently in two major assignments . . . as secretary and director of the American Board of Allergy and Immunology . . . and as representative to the American Board of Medical Specialties . . . "

The United Community Services of Metropolitan Detroit has named the executive vice-president of Sinai Hospital, **Julien Priver, MD,** as the 1979 Executive-of-the-Year in recognition of "his many years of leadership in the health field; for his consistent dedication to high standards in health programs; and for his commitment to serving not only Sinai patients, but meeting the health care needs of the general community."

Among the six recipients recognized at the recent University of Detroit President Cabinet Awards Dinner was **Joseph E. Kutz, MD,** a graduate of the University of Michigan Medical School. Doctor Kutz was honored for his pioneering work in techniques enabling severed hands and fingers to be replanted and reconstructed.

Appointed medical staff chairman at Hutzel Hospital is **James M. Pierce, Jr., MD.** Doctor Pierce currently is chief of urology at the hospital and professor and chairman of the urology department of the WSU School of Medicine. Hutzel Hospital also has announced the election of **Charles H. Wright, MD,** to its Board of Trustees. Doctor Wright is on the medical staff of Harper-Grace, Hutzel and Southwest Detroit hospitals and is an assistant clinical professor of obstetrics and gynecology at the WSU School of Medicine.

The citizens of many Michigan communites apparently still think their "doc" is someone special. The patients and friends of **Louis G. Ferrand, MD,** of Rockford, held a dinner in his honor to commemorate his 40 years of service to the community. The people of Crystal Falls named **Roger Untalan, MD,** "Citizen of the Year"; local doctors at the Dickinson County Memorial Hospital, Iron Mountain, and Anderson Memorial Hospital, Norway, were given a reception by the hospital staffs, auxiliary and friends in observance of National Physicians' Day, and the *Jackson Citizen Patriot* featured a special "thank you" article on **Ellis W. Adams, MD,** who will be retiring from his pediatric practice after serving the community for more than 30 years.

J. Dowd M.D.
OBSTETRICIAN
WE DELIVER

If you have any questions about the rigors of the Boston Marathon, contact **Norman Boeve, MD,** and **Henry Ottens, MD,** of Grand Haven, who have joined the expanding ranks of physicians participating in this annual event.

"Prevention of Russian Influenza by Amantadine" is the name of the article appearing in the March 9 *JAMA* co-authored by **Arnold S. Monto, MD, Robert A. Gunn, MD, Christopher L. King, MD,** and Mark G. Bandyk, MS, of the University of Michigan Department of Epidemiology, School of Public Health. The March issue of *The New Physician,* publication of the American Medical Students' Association, features "Periampullary Carcinoma" in its case records of the University of Michigan Medical Center Surgery Grand Rounds, edited by **Jay K. Harness, MD.** Moderator of the case history is **Thomas L. Dent, MD,** and the case presentations are given by **J. Ronald Oehler, MD,** and **Jeremiah G. Turcotte, MD.** Lansing internist **Richard C. Bates, MD,** contributed an article entitled, "I'm Tired of Losing Patients One Piece at a Time" to the March 19 *Medical Economics.*

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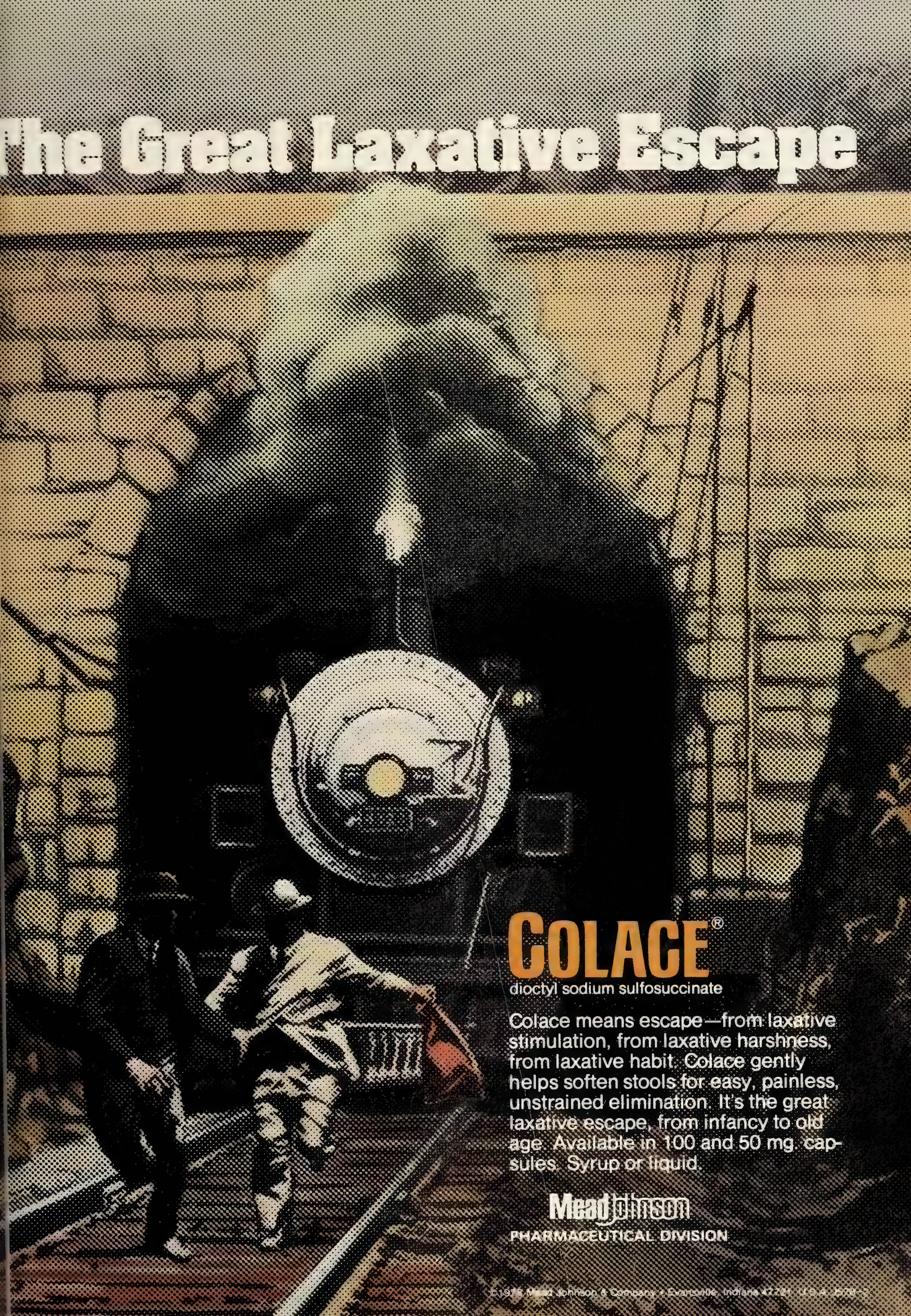
Bay City radio, TV and newspaper reporters interviewed Doctor Van Duyne.

MSMS Task Force on Medical Care Costs Chairman Frederick W. Van Duyne, MD, kept a full schedule in Bay City recently. As leader in the MSMS efforts to make physicians more cost conscious, Doctor Van Duyne met with news media and public throughout the day. His schedule was arranged by MSMS staff. (Photos by Mert Scholten.)

Doctor Van Duyne appeared on "Day by Day," half-hour local TV talk show.

At the Bay Economics Club, Doctor Van Duyne received a plaque of appreciation after addressing club members on medical care costs.



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2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

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Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

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Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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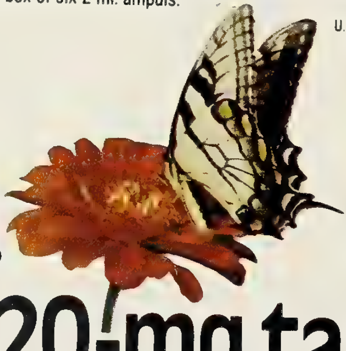

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Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml
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Recollections of two weeks providing medical care to the Navajo

By Orville W. Oughtred, MD
Mt. Clemens

I spent two weeks in the latter part of February working for the USPHS Indian Health Service at Crownpoint, near Gallup, New Mexico. The Crownpoint Service Unit is one of six hospital-based community health services maintained for the Navajo Indian Health Service.

This unit serves around 3,500 square miles. Canyons slash the semi-used land, ranging from 100-200 feet in depth. Contrasting prominences rise to 2,000 feet. The altitude is 7,000 feet with clear and sunny skies 90 percent of the time.

Navajo living conditions

Aside from uranium mining, and minor oil projects, there is little industrial work. Unemployment of the work force averages 75 percent. Twenty-five percent of the families have no visible means of support. The remainder make a living from occasional wage work, rug weaving, crafts, and livestock.

Many of the Navajo live in a hogan which is an eight sided one room log, stone, or earth dwelling with a chimney hole in the middle of the roof. These hogans are heated by wood-burning stoves. During the last two decades, small frame houses have been built. Very few dwellings have any sanitary facilities, electricity, refrigerators or fresh water. Some families that are fairly well-off live on diets of mutton, fried bread or tortillas, cereals, beans, potatoes, other vegetables and fruits, sweets, coffee and, less often, eggs and milk. The less well-off families eat mutton, fried bread or tortillas, potatoes, beans and drink coffee. Many eat only once or twice a day and occasionally go without food. Specific dietary deficiency is seldom seen. However, iron deficiency anemia does occur.

Communication with Navajo people is difficult because their language is radically different from English, both in structure and in sound. The Navajo have more than 10 different expressions for being sick. Many of the Navajo are unable to speak English well enough to describe their illnesses; medical discussions are conducted through interpreters.

Upper respiratory infection, tuberculosis, trachoma, dysentery, pneumonia, otitis media were among many of the diseases seen. Prenatal examinations were adequate and complete with Papanicolaou smear, prenatal profile and general physical examination, G C culture, rubella titer, VDRL all done on the initial visit. At 31 weeks, further laboratory studies were repeated along with a culture for strep.

The ratio of physicians to population was one to 2,600. Seven physicians are required at this service unit. During the time I was at Crownpoint, there were three MDs and one DO who were full-time, augmented by one graduate MD waiting to start his internship, and two medical students. The staff in the out-patient area was assisted by two nurse practitioners and two community health medics. The medics are generally of Indian blood with a special training program beyond that of RN, LPN, medical technician and so on. The Crownpoint Service Unit consists of approximately 120 personnel, over half of whom are Navajo.

Medical care delivery

Some of the older, traditional Indians still rely on curative, ritualistic, complicated ceremonies designed to restore physical and mental health. The younger Navajos in this area rely on medical care supplied by the Crownpoint Service Unit, which looks after the entire Eastern Navajo area.

Minor surgical and uncomplicated obstetrical, general medical and pediatric services are available at the hospital facility. About half of the admissions are pediatric. The out-patient clinic at Crownpoint is open at all times. The seriously ill and acute surgical and obstetrical cases are transported by ambulance to Gallup or Albuquerque.

Doctor Oughtred with Navajo blankets

Good, standard government medical records are kept, and everything in medical care to the patient is free.

The facility is usually short-handed and is in need of volunteers who, by the way, receive a modest stipend from the USPHS. The dedication and devotion of the staff here is of the highest quality and was an inspiration to me — even at my age, when inspiration is becoming elusive.

Let my express my feelings this way: On rounds, we saw a little 86-year-old Navajo woman who had been brought in from her solitary hogan because of the freezing weather. She had no relatives, no close friends. She was alone, trying to keep alive, looking after herself with none of the amenities we know. Doctor Gonzalez, one of the full-time staff physicians, said she would probably be allowed to go back to her hogan in warm weather.

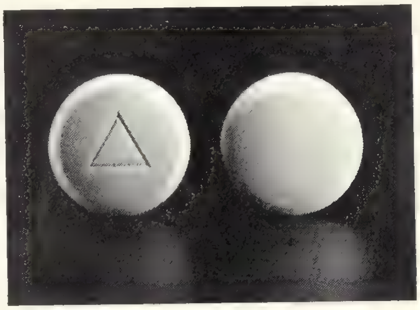
She looked impassively at me with fearless coal-black eyes which went far beyond me into the infinity of the past, present and future.

My thoughts were only of the present. I had just delivered my first Navajo breech baby and I was enjoying the fellowship of medical colleagues and the opportunity, if only for two weeks, of providing medical care for these native Americans of the East Navajo area.

Doctor Oughtred is an MSMS Councilor.

The Maker

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
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Washington, D.C. 20005

Mackinac Island service provides rare experiences for family practice residents

By Robert Vanden Berg, MD
Lansing

Mackinac Island may be small, but it has potential to do great things for the Michigan family practice residency programs.

Some background may help clarify how family practice has become involved in supporting the Mackinac Island Medical Center and the full time island residents.

In late 1978, Island Mayor Margaret Doud actively sought the advice of H. E. "Pat" Crow, MD, Lansing, on how to deliver health care to the Mackinac islanders. Doctor Crow is director of the FP residency program at E. W. Sparrow Hospital, Lansing, and treasurer of the Michigan Academy of Family Practice. He had previously aided Mackinac Islanders in getting health care from resident physicians.

Doctor Crow conceived a plan which would allow senior level family practice residents from all of the Michigan residency programs to spend two-week rotations on the Island year-round. In this way the islanders would get continuous medical coverage with the distinctive flavor of family centered care. The MAFP endorsed the residency rotation program in December.

First to stay

Because of my early excitement in the program, I was selected as the first resident to stay on the island.

Early in January, then, my family and I, Virginia residents for the past seven years, made the long journey to this small island somewhere in northern Michigan which neither of us had ever seen. The major portion of the first day was spent familiarizing myself with the medical facility, a clean white building with no less than three examining rooms, X-ray, lab, surgery and ER, and moving into our furnished apartment.

Patient flow over the first two to three days averaged eight to 10 visits. I sensed a definite testing of this new system and new doctor. Was I someone to be trusted and could they count on continued medical care? The apprehension fell away by week's end and we began planning for a well-baby clinic, a hypertensive screening clinic, and a CPR training/certification class.

On Friday of the first week we held our first well-baby clinic and managed to see and update immunizations on 37 children. Patients were then rescheduled for follow-up immunizations and protocols written on their charts. Each mother was given a record book of her child's visit. I believe the staff, the families, and myself felt good about the clinic and the way family practice care can be presented. Family units were being encountered and educated. Patients were participating in their own care and enjoying it. When office doors closed on Friday at 5 p.m. I felt family practice had a strong foothold in the community.

During the second week the patient load increased slightly and the variety of complaints increased. I was seeing geriatric patients, chronic hypertension, orthopedic problems, routine well baby, sore throats, physical exams, GYN problems. The medical center was operating efficiently, appointments were being scheduled in advance, as the community knew another doctor with the same skills and training was coming when I left.

At midweek the CPR course was held in the community center from 7 to 10 pm on two nights. Twenty-one persons came, 18 were certified and three recertified. Participation was 100 percent and enthusiasm ran even higher.

Felt training good

During my two-week stay on the island I transferred two persons to the Petosky Hospital and arranged for their care and admission by personally calling an attending physician. I found the physicians at the Burns Clinic to be cooperative and helpful in this respect and enjoyed the follow-up information they relayed to me.

As a family physician my own family occupies a position of highest priority. My experience on the island allowed me the pleasure of being with my family a great deal.

From an educational standpoint, I felt good about the training I had received in the residency program and I was able to pinpoint areas that need more work. It was good to have back-up supervision but also have the privilege to operate independently. The experience of helping run an office and participate in a rural community is impossible to duplicate in a controlled residency setting and probably can only be duplicated in an area like Mackinac Island.

Doctor Vanden Berg is chief resident of the Sparrow Hospital Family Practice Residency Program.

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Meetings

MSMS & AMA meetings

June 13 (Lansing), June 14 (Southfield), June 15 (Detroit) — Physicians Service Group Personal and Practice Financial Planning Seminar for physician and spouse, contact John Anthony, MSMS headquarters.

July 5-8 — MSMS Council, Birchwood Farm Golf and Country Club, Harbor Springs, contact: Warren Tryloff, MSMS headquarters.

July 22-26 — AMA Annual Meeting, Chicago Marriott Hotel, contact: AMA headquarters, 312/751-6000.

Aug. 27-Sept. 1 — AMA Special Joint Session on Medical Staff Leadership and Conflict Resolution, Wentworth-by-the-Sea, Portsmouth, NH, contact: AMA Department of Negotiations, 312/751-6647.

Sept. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24 — MSMS Conference on State Legislation, contact: Bruce Ambrose, MSMS headquarters.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters, 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

June 13-14-15 — 30th Annual Meeting and Educational Institute, Michigan Association of Hospital Auxiliaries, Grand Hotel, Mackinac Island, contact: JoEllen Lawrence, 8339 Childsdale Ave., NE, Rockford, 49341.

June 13-14-15 — Educational Institute for Nursing Administration, contact: Gary L. Pauly, Michigan Hospital Association, 2213 E. Grand River, Lansing 48912.

June 15-19 — Association for Behavior Analysis 5th Annual Convention, Hyatt Regency Dearborn, contact: ABA Program Committee, Dept. of Psychology, Western Michigan University, Kalamazoo 49008, 616/383-1629.

July 7-12 — Annual Meeting, Michigan Academy of Family Physicians, Holiday Inn, Traverse City.

July 9 — Michigan Ophthalmological Society Executive Committee Meeting, Wayne County Medical Society Building, contact: Susan Grimsley, 517/337-1351.

July — Institute of Gerontology Continuing Education Seminars, Teaching/Learning Communities in Neighborhood Setting (July 9-11), Drama and Literature Programs for the Elderly (July 9-11), Activity Programs for the Elderly (July 12-13), Music Therapy in Treatment Settings for the Elderly (July 14), Agency Administration: Fiscal Management (July 23-25), Counseling Older Adults and Their Families (July 23-27), Teaching of Aging in Community and Educational Setting (July 23-27), contact Dorothy Coons, Institute of Gerontology, Wayne State University 313/764-3493.

July 26-27 — Medical sculpture program for those involved in sculpture and science, contact: Towsley Center, Ann Arbor, 313/764-2287. Pre-registration required by July 1.

Aug. 8 — Emergency Services Deployment Seminar, Wayne State University, contact: Joanne Juhl, Wayne State University, 313/577-4707.

Sept. 23-26 — Toxic Substances in the Human Food Chain: Implications for Public Health Practice, University of Michigan Extension Service, Radisson-Cadillac Hotel, Detroit, contact Jane Elgass 313/764-5307.

Sept. 25 — Transition: The Challenge, Council on Continuing Education of the American Nurses Association, University of Michigan, Ann Arbor, contact: Elizabeth A. Allen, RN, Associate Professor of Nursing, 1355 Catherine Street, Ann Arbor, 48109.

1979 MSMS Annual Scientific Meeting to include ‘alpha-omega’ courses

By Judith Marr, Editor

Alpha to omega — the Greek letters for beginning and end — provide the theme for a group of special courses planned for the 1979 MSMS Annual Scientific Meeting Nov. 13-14-15 at the Hyatt Regency Dearborn.

Annual Scientific Meeting Chairman Samuel M. McMahon, MD, Lansing, and directors for those special courses are stressing how each of their topics applies to the patient from birth to death — from alpha to omega.

Examples of sessions taking that approach to better help the practicing physician keep up-to-date are the courses on the endocrine system, urinary tract infections, hematuria and the respiratory system.

The alpha-omega idea was suggested by Edward Cotton, MD, Marcellus, member of the Annual Scientific Meeting Advisory Task Force. Doctor Cotton saw the idea carried out at the American Academy of Family Physicians’ Family Practice Review in April 1978, and felt it worked quite well.

“The MSMS task force seemed to like the idea. We have decided to use it with a few courses and see how it works,” he said.

“We’re thinking about the family physician as we plan the Annual Scientific Meeting,” he continued. “They treat the entire range of patients, from newborns to the elderly.”

Management by age

“Medical problems often are handled differently depending upon the patient’s age. Our alpha-omega courses are planned to run the spectrum of disease states and treatments in the different age groups.

“We hope physicians attending the Annual Scientific Meeting will come away with a better understanding of things to look for in newborns, children, adolescents, young adults, the middle-aged and the elderly.”

Chairman of the alpha-omega sessions on the endocrine system, urinary tract infections, hematuria and the respiratory system are, respectively, David Rovner, MD, Michigan State University; Joseph Cerny, MD, University of Michigan, and Michigan Branch, American Urological Association; Gerald F. Conway, MD, Michigan Branch, American Urological Association and Doctor McMahon.

In addition to the alpha-omega sessions, a wide variety of practical courses on daily medical care are planned. They will cover such subjects as ventricular premature beats, acid-base and fluid electrolyte balance, hypertension, chronic ear disease, common office infections, common errors in ECG interpretations, nuclear medicine, gastrointestinal bleeding, ischemic heart disease, common pediatric problems, the dizzy patient, allergy and asthma in children, reasons for cancelling surgery, lower back pain, stroke syndrome and new respirators and techniques for treating respiratory failure.

Courses on emotions

Courses dealing with patients’ emotional well-being include those on alcoholism and drug dependence; psychological problems of critically ill patients; problems of menopause; application of psychoanalysis to medical care; a medical ethics workshop; and the psychology of abortion.

Courses in the public health area will take up sports medicine and industrial environmental pollutants.

Working with Doctor McMahon to organize the meeting are Doctor Cotton; Frank Cox, Jr., MD, Detroit; Thomas F. Downham II, MD, Taylor; Kenneth Krabbenhoft, MD, Detroit; David R. Rovner, MD, East Lansing; James C. Stanley, MD, Ann Arbor; and Joan C. Stryker, MD, Detroit. MSMS staff person in charge is Sherry Fent, coordinator of CME programming. Working closely with the advisory task force for the 1979 Scientific Meeting are members of the CME Programming Committee, headed by Carl F. Hammerstrom, MD, Marquette.

Further information may be obtained from Sherry Fent at MSMS headquarters, 120 West Saginaw, East Lansing, 48823 (telephone: 517/337-1351).

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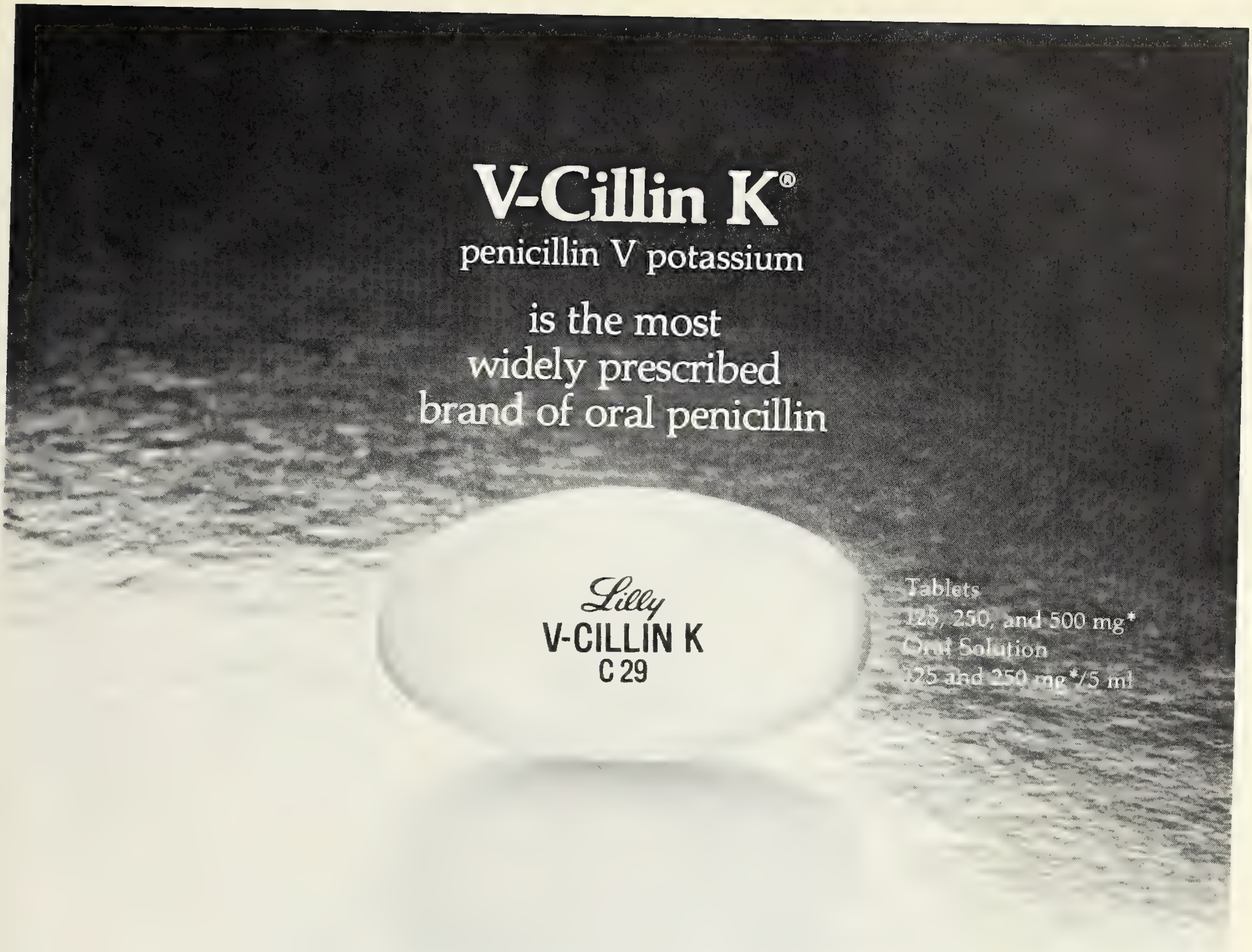

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Detroit's Health Care Institute now serving patients

Patient services now are being offered at Wayne State University's new Health Care Institute, the $48 million primary care facility under construction since 1974. Radiology and other intensive service areas were expected to begin operation June 1.

The Health Care Institute is the largest multidisciplinary primary care program in the United States, offering both patient services and educational opportunities for those in a variety of health professions.

Affiliated with Wayne State University, the professionals who practice at the institute have faculty status in the schools and colleges of medicine, nursing, social work, pharmacy and allied health professions, and liberal arts. It is the intent of WSU to foster a symbiotic relationship between the treating and teaching functions of the university and the institute.

The Health Care Institute under construction

Service range

A non-profit corporation, the Health Care Institute offers a full range of primary care and medical specialties. There are more than 30 specialty groups.

For patients who need hospital care, the five hospitals of the Detroit Medical Center are connected to one another and the Institute by a concourse, with the exception of Hutzel Hospital one block away. Each hospi-

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tal specializes in certain kinds of care to avoid duplication of services.

Harper Hospital specializes in general hospitalization for adults, with a concentration on cancer, cardiovascular disorders, orthopedic problems, phychiatry, eye surgery, and brain and nervous disorders.

Hutzel Hospital provides obstetrical and gynecological care; Children's Hospital of Michigan, emergency and general pediatric care; Rehabilitation Institute, rehabilitation programs for the physically and visually handicapped; and Detroit Receiving Hospital (formerly Detroit General) is the adult medical and surgical trauma unit.

Of the Health Care Institute's building cost, $43.7 million came from the State of Michigan and $4.6 million from the federal government. In addition, its program development fund is also provided by the State of Michigan. The building is approximately 450,000 gross square feet and has nine floors.

Floor plan

The shape of the building is in three interlocking cruciforms, or crosses. Each cross has a lightwell in the center. The cruciform design provides pods for individual services, offering a size more like that of a typical office setting for each service.

The following is a floor-by-floor breakdown of the various services offered by the Institute:

Level One: Computer center, pharmacy, radiation oncology.

Level Two: Also called the Plaza level, has the administrative, business, finance and personnel offices, along with patient services, cashier, pharmacy, patient education, conference center and central reception.

Level Three: Human functions — stress testing, EKG testing, pulmonary function tests and others, and radiology and pathology.

Level Four: Family Practice Center, general pediatrics, life stress, primary care nursing, university services, child day care, health assessment, radiology, laboratory and pharmacy.

Level Five: General internal medicine subspecialties, dermatology, allergy, gastroenterology, otolaryngology, audiology and pharmacy.

Level Six: Adult surgery, orthopedics, neurology, neurosurgery, urology and gynecology.

Level Seven: Oncology, general internal medicine subspecialties, rehabilitation services.

Level Eight: Adult and adolescent psychiatry, clinical psychology, human development resources.

Level Nine: Ophthalmology, visually handicapped services.

Fees and working relationships at the Institute will be governed by the Physicians Practice Plan, according to WSU Governor George Edwards. Edwards, chairman of the Board of Governors' Medical Affairs Committee, said the Plan will be established as a non-profit, tax exempt entity if legal aspects can be worked out.

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Rep. Bryant, minority leader, wants taxpayers to determine priorities

By Willah Weddon
Special to **Michigan Medicine**

A $500,000 liability limitation would have been placed on negligence or malpractice action awards, under a bill (HB 4215) introduced during the past session in the Michigan House of Representatives by Rep. William R. Bryant, Jr.

In addition, any awards above $50,000 would have been disbursed in monthly installments according to a schedule established by the court after medical, litigation and legal representation costs had been paid.

"I have tried to restrict high awards to keep people from getting huge lumps of money," Bryant explained. "I drew up this bill because it's needed.

Breaking patterns

"It's not my job to be popular with the trial lawyers," he responded quietly when reminded this philosophy does not fit the pattern generally approved by the law profession, of which he is a member.

Elected House Minority Leader the beginning of this session, the Grosse Pointe Farms Republican doesn't plan to introduce any bills personally. "But I intend to see similar legislation will be introduced," he pointed out.

"I've also sponsored other bills to restrict contingency fees," he said. "The (State) Supreme Court has taken care of this to some degree."

The six-foot, 40 year-old attorney goes about his House role methodically and undramatically. In 1975 he was elected Republican floor leader by his colleagues and now holds the top party leadership post in the House.

"The Caucus was ready for someone committed to work with members in a coordinated effort to give the Republicans an identity," he said, explaining his rise in the ranks.

In an effort to acquire this identity for the 40 House Republicans (reduced by two in the Nov. 7 election), Bryant publicly insisted he would be no rubber stamp for the Governor.

In this typically straight-forward, if somewhat blunt, manner he began his term by chaffing the chief executive to the point that an aide pointed out the Governor was not particularly distressed over the matter. At best, future cooperation between the two is not expected to equal that which existed while former Rep. Dennis O. Cawthorne served as Minority Leader. (Cawthorne did not seek reelection to the House last November.)

'Taxpayers' Agenda'

Seated behind his desk in the attractively furnished, light-filled and large House minority leader's office on the first floor of the Capitol building, Bryant discussed the "Taxpayers' Agenda." This agenda, or list of priorities, is being drawn up by the Republicans based on desires of the people rather than those set by the legislature itself.

"With 13 freshman members and two others in by special election during the last session, we really feel we have a revitalized caucus," he said. "We'll shake off the doldrums of the minority syndrome we've found ourselves in, in past years."

Rep. Bryant

"We've made a commitment to the Taxpayers' Agenda. We think it should be the people of Michigan who set the legislative priorities," he continued. "We plan to get out of Lansing and do whatever we can to solicit the ideas and views of people as to what our priorities should be."

To this end, Bryant, Rep. Connie Binsfeld (R-Maple City) and Rep. Paul Henry (R-Grand Rapids) have visited 14 cities. They are sponsoring radio spots asking for people's ideas, polling the public and establishing advisory groups.

"A portion of the Taxpayers' Agenda, in our starting document, involves an all-out effort for a first class mental health system; particular attention to the health problems of senior citizens; maternity and early child care; and the handicapped," he said.

As for national health insurance, he said, "I'm cautious about it. I don't much like socialized anything. But we have to find some more acceptable mechanism to assure people basic health care."

The following article is the tenth in a series. The articles, written especially for* Michigan Medicine *by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.

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Business

Joint Ownership Not Always Best Answer

(The following article is reprinted with permission from the Jan. 10, 1977, issue of The State Journal, Lansing, MSMS/PSG Financial Services Director Robert Stanziano was at that time senior trust officer for Michigan National Bank, a position he left to join MSMS. The advice provided by this article still stands, Mr. Stanziano says.)

By Sue Burzynski
The State Journal, Lansing

When you say "I do," are you joining hands and everything else too — money, property and all other assets?

After the wedding, many couples rush to the bank to put all the savings and checking accounts in joint ownership along with the house and the car.

They assume if one spouse dies, the other will immediately be sole owner of everything without a will.

That may be true. But financial experts say joint ownership is not always the key to avoiding probate or high estate taxes when a spouse dies.

And, in these days of rising divorce rates, joint ownership might present other problems too.

Take Alice and John. A picture of bliss on the wedding day, they put all the cash gifts and their individual savings into a joint account.

Nine months later, John wanted to call it quits. Before Alice caught on, he withdrew all the money in their joint savings account.

That is perfectly legal. In a joint savings account, either party has total control over the funds. It's a disadvantage of a joint account each couple must consider.

Robert Stanziano, senior trust officer for Michigan National Bank, said: "You can't safeguard against everything. If young people start separating everything right from the start, I don't think the marriage will work out. If it all becomes 'mine and yours' how do you decide who pays for the roast?"

Gary Mielock, of the Financial Institutions Bureau, added: "Just talking about the potential problems could lead some couples to separation with a 'you don't trust me' attitude."

One alternative is putting the money into a joint account with rights of survivorship, but requiring both signatures to withdraw funds. That would solve potential dispute problems, but it also eliminates the convenience of a joint account.

And then there are taxes. Many people are under the mistaken notion that putting assets into joint accounts will save heavy federal estate taxes if one of the account holders dies.

They assume since the survivor's name is already on the account, the money will not be taxed. Not so.

Until Jan. 1, the federal government usually assumed 100 per cent of the money in a joint account belonged to the first to die (for tax purposes.) Unless the surviving spouse could prove what he or she contributed, the entire account was taxed.

Under the tax reform law, effective this month, only 50 per cent of a joint account is presumed to have been supplied by the deceased spouse. If the husband is the only wage earner, however, there should have been gift taxes paid on the 50 per cent belonging to the wife.

If there aren't any gift tax receipts, the wife may have to prove she contributed to the account. But this problem usually arises only in large estates.

Before you take all your money out of joint accounts for fear of taxes, the experts note, you should know the federal estate tax will not affect your estate (total assets including life insurance, house, cars and all other income) if it involves less than $120,666.

And, by 1981, that figure will rise to $175,000.

"If there are small amounts of money involved, there should be no problem with joint ownership," said Stanziano. "The federal estate tax is not going to be an objection to jointly owned property if estates are less than $175,000."

Mielock agreed. "For the average individual it (the federal estate tax) is not going to be that big of a consideration. If you've got an estate worth $250,000 or $300,000 you've probably got a fairly sophisticated couple who are not going to have that much in joint accounts."

"The new law liberalized the amount you can have in an estate before it is subject to taxes," Mielock added, "to make it easier for the small taxpayer."

If an estate reaches $75,000 or $80,000, Mielock suggested seeing an accountant, attorney, banker or some other estate planner for advice.

"At that point you're getting close to $120,000 and you want to start planning a little bit about what you're going to do with your assets." To figure out what your estate is worth, add up a list of everything your spouse could sell to make money if you died, he said.

Substantial estate

Both experts agreed if an estate is substantial enough to be seriously affected by estate taxes it would be wiser to avoid joint accounts.

Many times couples place all of their assets in joint ownership to avoid probate costs and time delays if one spouse dies.

Estate planners say joint ownership works to avoid probate only for childless couples who remember to put every single posession in both names. And, they say very few people remember everything.

(Continued on page 344)

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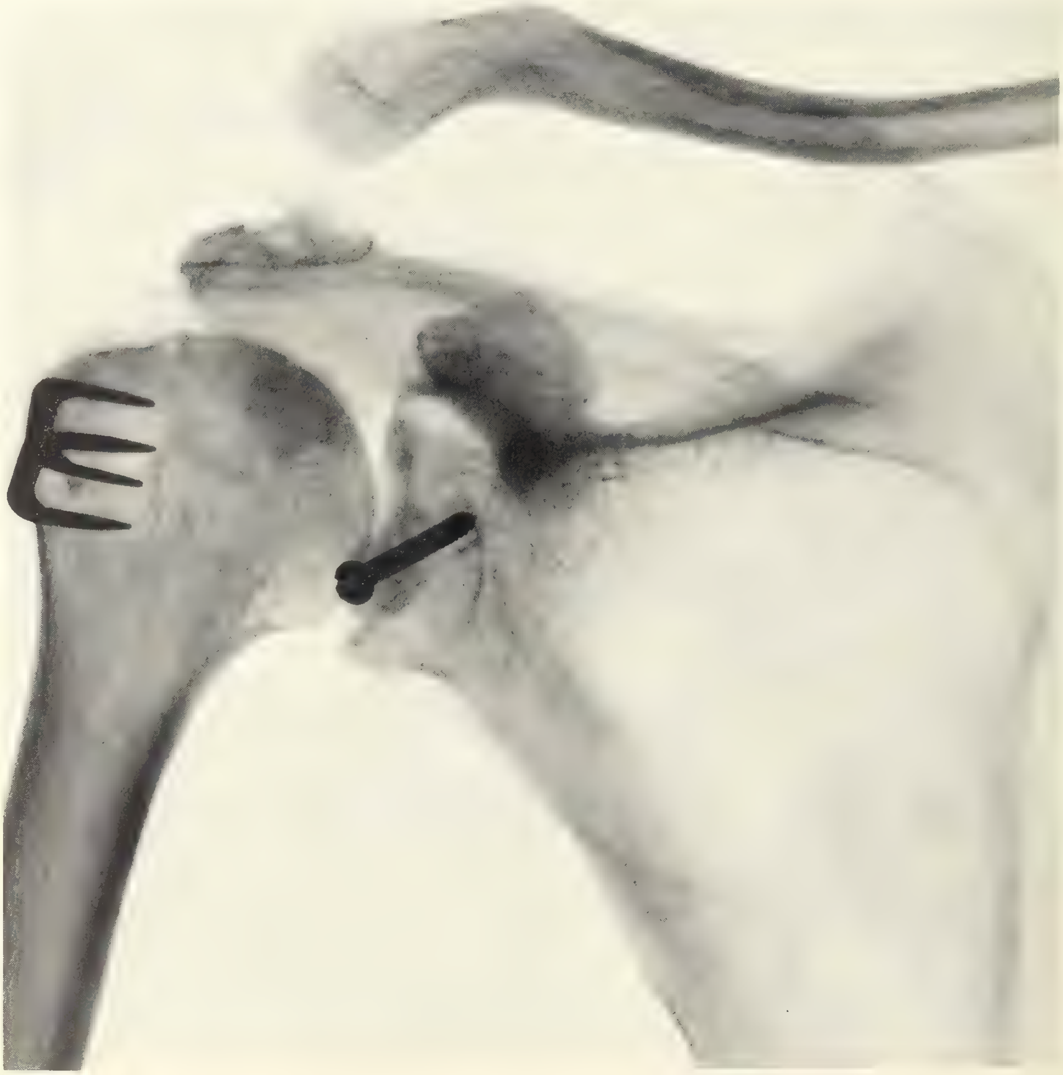
Can you identify this radiograph?

Radiograph of the right shoulder of an unidentified Black female person found on August 30, 1978 in Jackson County, Michigan. Approximately 28 to 40 years.

The Radiograph illustrates the surgical implantation of two large staples into the lateral aspect of the greater tubercle of the right humerus and a 32 mm. (1¼") screw into the anterior border of the glenoid fossa of the right scapula. The screw was apparently intended to hold a small bone graft to the articular surface. Possibly this procedure was intended to stabilize a chronic shoulder dislocation.

If you have any information that may assist in identifying this person, please contact your nearest State Police Post or call Lt. Tim Ryan, Jackson State Police Post (collect) (517) 782-0463. Complaint No. 41—5007—78.



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Makes Sense

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The triamterene in 'Dyazide' limits potassium loss and provides an additive diuretic effect to that of the hydrochlorothiazide component.

In Hypertension

As the hydrochlorothiazide in 'Dyazide' lowers blood pressure, the triamterene component limits potassium loss.

Serum K⁺ and BUN should be checked periodically particularly in the elderly, diabetics, and those with suspected or confirmed renal insufficiency (see Warnings). If hyperkalemia develops, substitute a thiazide alone.

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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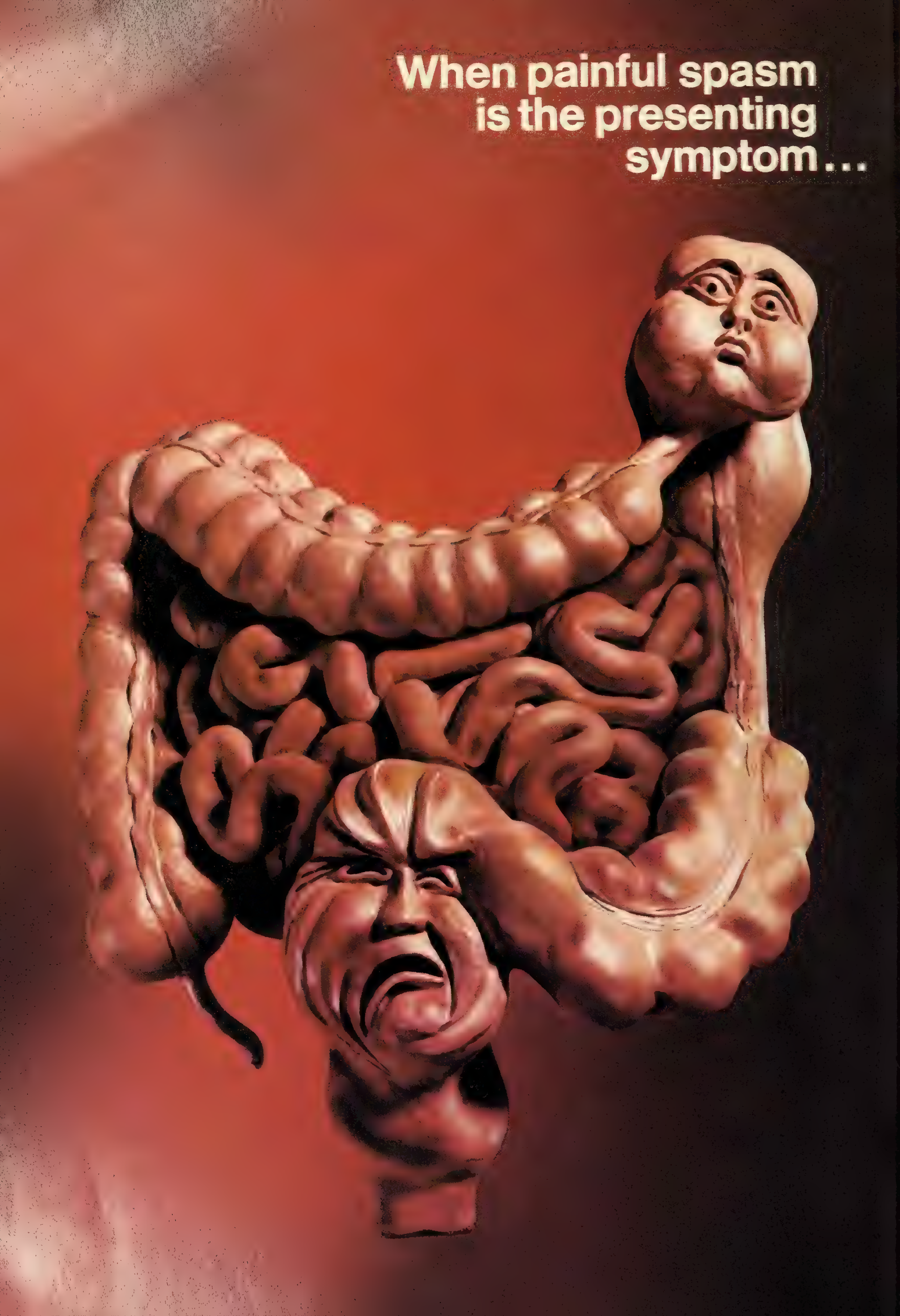
When painful spasm
is the presenting
symptom...

.in the functional bowel/irritable bowel syndrome*

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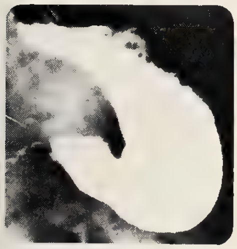
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

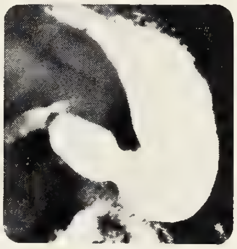
Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs

Usual Dosage Bentyl 10 mg. capsule and syrup *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily. *Infants.* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults* 1 tablet three or four times daily Bentyl Injection *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE. The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A

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JOINT OWNERSHIP/*continued*

But both Stanziano and Mielock suggest couples — even those with all property in joint ownership — need a will.

If a childless couple dies in an auto accident, for instance, and the husband lives 15 minutes longer than the wife, he becomes sole owner of all their joint property for that 15 minutes. When he dies, the property is inherited by his family alone.

Stanziano also cautions against trying to avoid probate by putting all assets into joint ownership with an eldest child, assuming, if the parents die, the child will split the estate with his siblings.

"Joint ownership with a child is taboo," he said. "Many times, the oldest child will keep it all and say to hell with his brothers and sisters.

Stanziano said he would not recommend joint ownership of accounts with anyone but a spouse. He noted widows or widowers will often name a friend on a joint account and instruct the friend to distribute the money to his children after death, but the money actually belongs to the friend upon death. "I've heard of many older people who lost all of their money to a friend because of that."

"There is no easy answer," said Mielock about joint accounts. Though with a small estate joint ownership offers the opportunity to pass quickly from one spouse to another, all the experts agree, a will is still necessary.

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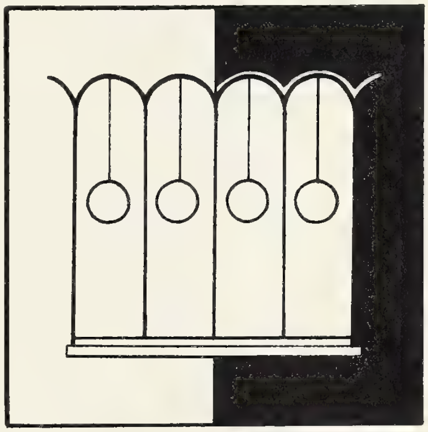

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(Continued on page 348)

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Physicians report greater stress due to malpractice suit threat

Physicians are reporting new stresses resulting from medical practice, according to survey results recently published in the *Journal of the American Medical Association.*

Graduates of Case Western Reserve School of Medicine from 1956 through 1965 were queried regarding satisfactions and stresses in practicing their profession. Results were compared to a similar study of graduates from 1935 through 1945.

The more recent physician respondents noted sources of stress that were not problems for the earlier group. Heading the list was the problem of malpractice suits. Physicians increasingly are doing less because risks to themselves are higher. They are not providing procedures that may benefit the patient if they are delicate and somewhat risky to perform.

Other new stress factors mentioned were fear of violence against themselves and their families by disgruntled patients and the necessity of participating in peer review of colleagues.

Satisfations, which evolve around helping patients, solving problems and developing relationships with patients and their families, remained approximately the same for the 1935-1945 group and the 1956-65 group. Both groups also reported a major dissatisfaction in lack of leisure time and time pressures of work.

MDPH has new environmental health unit

A Chemicals and Health Center has been established by the Michigan Department of Public Health to coordinate efforts in the area of environmental health.

The Chemical and Health Center's responsibility will be to possess a broad awareness of environmental health concerns and to identify new areas that are not getting proper attention. The center will coordinate activities within the Health Department and with other state agencies, including the Toxic Substance Control Commission.

Questions or comments about the new center can be addressed to Chemicals and Health Center, Michigan Department of Public Health, P.O. Box 30035, 3500 N. Logan, Lansing, 48909.

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Category I courses

***Michigan Medicine** each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: June 11-12, Issues in Hospice Care for the Elderly: A Forum. Location: U-M. **Sponsor:** Institute of Gerontology, The University of Michigan; The University of Michigan Medical School; and the United Way of Washtenaw County. **Cost:** $75. **Contact:** Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4102. **Approved for:** 11 hours of Category I Credit.

Date: June 13-15, Drugs, Alcohol, and the Elderly: Use/Abuse/Misues. Location: Art and Architecture Building, 2000 Bonisteel Blvd., North Campus, University of Michigan. **Sponsor:** Institute of Gerontology, U-M. **For:** health professionals, including pharmacists, nurses, social workers, psychologists, health educators and state agency personnel who provide services to the elderly. **Cost:** $95. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4102. **Approved for:** 18 hours of Category I credit.

Date: June 17-23, Advanced Institute in Methods of Immunological Diagnosis. Location: Cranbrook Educational Community, Bloomfield Hills. **Sponsor:** World Health Organization Collaborating Laboratory for the Serology of Autoimmune Diseases at Wayne State University School of Medicine. **Cost:** $600. All inclusive. **Contact:** Noel R. Rose, MD, PhD, Dept. of Immunology and Microbiology, WSU School of Medicine, 540 E. Canfield, Detroit 48201. **Approved for:** 60 hours of Category I Credit.

Date: June 18-22, Psychology of Aging. Location: Art and Architecture Building, 2000 Bonisteel Ave., North Campus, University of Michigan. **Sponsor:** Institute of Gerontology, U-M. **For:** Social Workers, physicians, teachers, researchers, and others interested in the psychological impact of major life changes during middle and later life. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 E. Liberty, Ann Arbor 48109, 313/763-4101. **Approved for:** 27.5 hours of Category I credit.

Date: June 22-24, Urology Outing. Location: Bay Valley Inn, Bay City, Michigan. **Sponsor:** Wayne State University. **Cost:** $150. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 1206 Scott Hall, 540 East Canfield, Detroit 48201. **Approved for:** 12 hours of Category I credit.

Date: June 24-29, Michigan Academy of Family Physicians Fifteenth Annual Northern Michigan Summer Program. Location: Hilton Shanty Creek, Bellaire, Michigan. **Sponsor:** University of Michigan, Towsley Center for Continuing Medical Education. **Cost:** $225 or $55 per day. **Contact:** Towsley Center for Continuing Medical Education, Ann Arbor 48109. **Approved for:** 21.5 hours of Category I credit.

Date: June 28-29, Intraocular Microsurgical Workshop, the Ocutome™ and Fragmatome™ Systems. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Ophthalmology. **For:** Ophthalmologists. **Cost:** $400. Pre-registration required. **Contact:** Towsley Center for Continuing Medical Education, Ann Arbor 48901. **Approved for:** 16 hours of Category I credit.

Date: July 24-26, Annual Meeting, Michigan Chapter, American Academy of Pediatrics. Location: Shanty Creek Lodge. **Program by:** Wayne State University Department of Pediat-

(Continued on page 352)

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakwood Hospital, Dearborn
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

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Michigan State Medical Society

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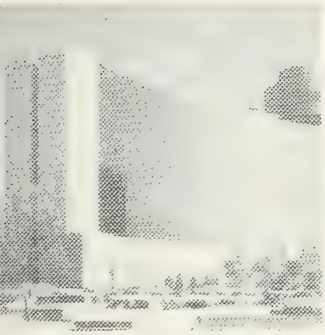

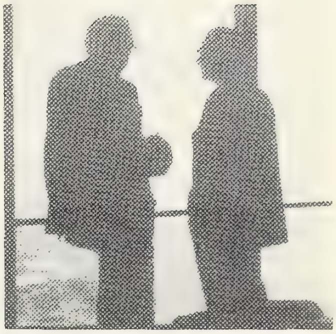

rics. **Contact:** Robert S. Holm, MD, 515 Lakeside Drive, S.E., Grand Rapids 49506, 616/774-9115. **Approved for:** 7 hours of Category I credit.

Date: July 26-27, Coller Penberthy Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center. **For:** Physicians interested in an update on medical advancements. **Cost:** $25. **Contact:** Norma Powers, Munson Medical Center, Sixth and Madison Streets, Traverse City 49684. 616/947-6140. **Approved for:** 9 hours of Category I credit.

Date: July 30-31, Speech and the Coming of Age: Prevention, Amelioration, and Treatment of Communication Disorders. Location: University of Michigan. **Sponsor:** Institute of Gerontology, U-M. **For:** Physicians, health specialists, and others who work directly with the elderly. **Cost:** $65. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 East Liberty, Ann Arbor 48109. 313/763-4101. **Approved for:** 10 hours of Category I credit.

Date: Aug. 10-12, ECG Interpretation and Arrhythmia Management. Location: Shanty Creek Hilton, Bellaire. **Sponsor:** International Medical Education Corporation. **Cost:** $202. **Contact:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. 800/525-8646 Toll free. **Approved for:** 15 hours of Category I Credit.

Date: Aug. 16-19, 11th Annual Summer Conference of the Michigan Ophthalmological Society. Location: Grand Hotel, Mackinac Island. **Cost:** $75. **Contact:** Susan Grimsley, MSMS headquarters. **Approved for:** 7 hours of Category I credit.

Date: Sept. 7-9, Diagnostic Ultrasound. Location: University of Michigan, Ann Arbor. **Sponsor:** Towsley Center for Continuing Medical Education. **Cost:** $160., physicians; $95., physicians-in-training; $95., technologists. **Contact:** Floyd C. Pennington, PhD, Director, Office of Continuing Medical Education, U-M, Ann Arbor 48109. **Approved for:** 16 hours of Category I credit.

Date: Sept. 8, Diagnostic Problems in Neuropathology. Location: St. John Hospital, Detroit. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, or John G. Batsakis, MD, Dept. of Pathology, University of Michigan Medical Center, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: Sept. 10-Nov. 12, Pediatric Seminar IV. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 20 hours of Category I Credit.

Date: Sept. 19-21, Real Time Ultrasound for the Private Obstetrician/Gynecologist. Location: University of Michigan, Ann Arbor. **Sponsor:** Department of Obstetrics and Gynecology. **Enrollment:** Limited to 25, pre-registrants only. **Cost:** $500. **Contact:** Towsley Center for Continuing Medical Education, Ann Arbor. 313/764-2287. **Approved for:** 21 hours of Category I credit.

Date: Sept. 26, Diabetes Update. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Oct. 18-19-20, Implant Surgery for Joints and Tendons in the Hand. Location: Blodgett Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand, Blodgett Memorial Medical Center. **Cost:** $250. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. 616/774-0440. **Approved for:** 19.5 Category I credits.

Date: Nov. 5-9, Principles of Milieu Practice: Working With the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** Institute of Gerontology. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 E. Liberty Street, Ann Arbor. 313/763-4101. **Approved for:** 30 hours of Category I credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 28, Updating Core Knowledge in General Surgery. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

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CATEGORY I/*continued*

Date: Jan. 16, 1980, Hypertension. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236. (313/343-4000). **Approved for:** 8 hours of Category I credit.

Date: March 19, 1980, Infectious Diseases in Obstetrics and Gynecology. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: May 21, 1980, Medical Therapy in Family Practice. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

MSMS reviews, continues contracts with reserve funds managers

The MSMS Board of Managers and Ways and Means Committee are continuing MSMS contracts with Oppenheimer Capital Corporation and Sabl Associates, managers for the society's two reserve funds.

The Board of Managers and committee members at their most recent review on April 19 were satisfied with the gain in the two funds shown by the money managers. They elected to continue their contracts at that time.

The board receives monthly statements, listing the holdings in the two funds and meets quarterly to review the progress. These reports are shared with the House of Delegates Ways and Means Committee, acting as the House of Delegates' fiscal watchdog.

The April 19 review showed the two fund managers' performance compares favorably with other money managers with similar investment objectives. Data for the review were presented by Prescott, Ball and Turben, MSMS investment monitors.

The MSMS Board of Managers in 1977 undertook the important task of selecting new money managers for the society's two reserve funds. The performance of the funds had not met the objectives of the board and they decided a change must be made.

With the aid of the Lowry Investment Advisory Service of Prescott, Ball and Turben Company, the board made an exhaustive search among the hundreds of registered investment advisors, or money managers.

After interviewing several quality firms, the board chose Oppenheimer Capital Corporation to manage the $376,000 in the Capital Reserve Fund and Sabl Associates to manage the $270,000 in the Creative Reserve Fund. The two firms took over the management of the funds in Feb. 1978.

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Sidney Adelson, MD
Southfield

Sidney Adelson, MD, former chief of the outpatient department at Harper Hospital, died March 30 at the age of 69. Doctor Adelson, of Southfield, was a 1933 graduate of the University of Michigan Medical School. He practiced medicine in Detroit at Harper, Sinai and Crittenton hospitals until his retirement three years ago. He was a fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine. Doctor Adelson was also former medical director of the Alexander Hamilton Life Insurance Company.

Sidney Dolgoff, MD
Dearborn

Sidney Dolgoff, MD, 64, an internal medicine specialist who practiced in Dearborn for 25 years, died April 21. Doctor Dolgoff was on the staff of Oakwood Hospital in Dearborn and medical director of Allen Park Convalescent Home. He was an instructor for Oakwood Hospital and a graduate of the University of Illinois College of Medicine.

Louis S. Lipschutz, MD
Troy

Louis S. Lipschutz, MD, past director of psychiatry at Wayne County General Hospital and a promoter of community mental health facilities, died April 13. He was 74. Doctor Lipschutz, of Troy, taught seminars to physicians and social workers on psychiatry and was a professor in the school of social work at Wayne State University. Born in Russia, he came to the United States as a child and graduated from the University of Michigan Medical School in 1930. He was formerly chief psychiatrist and director of psychiatry at Wayne County Hospital and president of the Michigan Society of Psychoanalysis. He also served on the staffs of Detroit Receiving, Veterans, Sinai and the University of Michigan hospitals. Doctor Lipschutz was instrumental in the opening of the Wayne County Mental Health Clinic.

Herbert A. Raskin, MD
Birmingham

Herbert A. Raskin, MD, 59, of Birmingham, a psychiatrist and adviser on alcohol and drug abuse, died April 5. He practiced psychiatry in the Detroit area for 25 years and was a clinical professor with Wayne State University. He was appointed in 1971 to the National Advisory Council on Alcohol Abuse and Alcoholism. From 1964-1972 he was consultant on drug and alcohol abuse to the Japanese government and was a drug abuse consultant to Mexico from 1972-73. Doctor Raskin addressed the first White House Conference on Narcotics and Drug Abuse in 1962. He received the distinguished service award from WSU in 1977. He was medical director and past president of the Michigan Psychiatric Society, a charter member of the American Academy of Psychiatry and the Law, and a charter member of the Michigan Association of Law and Psychiatry.

Sally B. McIntyre, MD
Lansing

Sally B. McIntyre, honorary life member of the Michigan State Medical Society, died May 1 in Lansing, Mrs. McIntyre was First Secretary and Treasurer of the MSMS Auxiliary and served as President from 1931-32. Widow of Dr. J. Earl McIntyre, she was MSMS historian for 20 years. In 1950 she conducted the installation ceremony for incoming officers and continued to do so each year. A resident of Lansing most of her life, Mrs. McIntyre was secretary to two Michigan governors and actively involved in civic affairs. She is survived by her son, Jack B. McIntyre, MD, Rochester; two grandchildren; and one great grandson; and two sisters.

National Computer aids U-M in treatment of birth defects

The University of Michigan's Mott Children's Hospital is now linked with a new national computer network to improve treatment and advance understanding of birth defects.

The U-M Hospital and only 12 other institutions are part of the new Birth Defects Information System funded by the National Foundation-March of Dimes. Roy D. Schmickel, MD, is in charge of operating the system at the U-M.

The network links hospitals with a central computer at Massachusetts Institute of Technology where information on any one of 1,000 different birth defects is available at the touch of a few keys on a computer terminal.

Pediatric geneticists in the U-M's Mott Hospital and Holden Perinatal Unit will use the system to treat children and exchange and compile information on birth defects. The computer system also will provide information on birth defect cases at no charge to physicians elsewhere in Michigan and nearby states. They may call and "consult" both the computer and the U-M's specialists.

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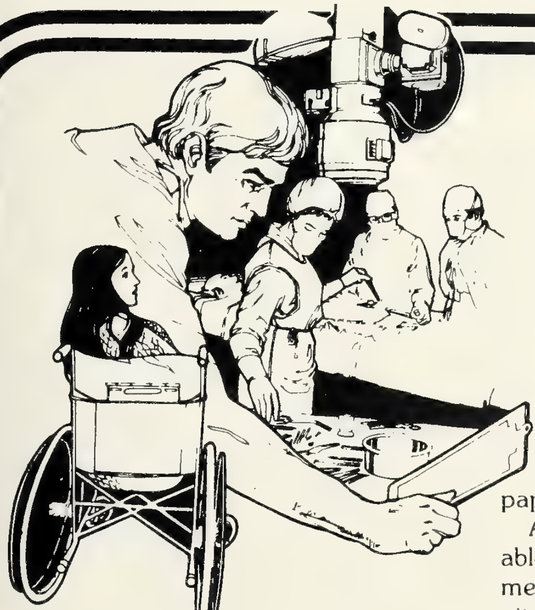

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The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

ANESTHESIOLOGY Resident Training Program seeks qualified Michigan applicants. Experience in general practice or primary care preferred. Enquire: Lucien E. Morris, MD, Department of Anesthesia, Medical College of Ohio, Caller Service #10008, Toledo, Ohio 43699.

NORTHERN MICHIGAN UNIVERSITY located in beautiful Northern Michigan has a position opening for a MEDICAL DIRECTOR — Student Health Center. Minimum: M.D. degree, current Michigan license or eligible for a Michigan license, 2-5 years experience (in medical administration) and interest in working with the college age group. Must provide medical direction to and work with two physicians, nurses, pharmacist, and medical technician. Full-time position, 12 month contract. Attractive fringe benefits, salary competitive and negotiable. Send resume and letter of application to Mr. William H. Clark, Director of Personnel, Northern Michigan University, Marquette, Michigan 49855. AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER.

GENERAL PRACTITIONER — to provide medical care in a small state facility for the mentally retarded, located in a rural setting in Michigan's beautiful Upper Peninsula. Current salary $46,625 plus a liberal Civil Service fringe benefit package. Limited housing available at moderate cost. Write Steven A. Myers, M.D., Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, Michigan 49868.

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PEDIATRICS, Educational Program Director. Applications are being accepted for this full time staff position with the Southwestern Michigan Area Health Education Center. This is a challenging opportunity in a clinically stimulating environment with an academic atmosphere. To be considered, an individual must be a fully trained pediatrician and certified (or imminently so) by the American Board of Pediatrics. Duties and responsibilities will encompass many areas of activity including undergraduate, graduate and continuing medical education. A complete job description is available on request. Compensation will include a generous stipend and fringe benefits package as well as a regular appointment to the faculty of the College of Human Medicine of Michigan State University. For details Contact: Robert M. Nicholson, MD, Executive Director, Southwestern Michigan Area, Health Education Center, 252 East Lovell Street, Kalamazoo, Michigan 49007. 616/383-7896.

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HOUSE OFFICER II — INTERNAL MEDICINE Minimum 1 year training in Endocrinology and 1 year in Internal Medicine. Position open September 1, 1979. Salary $16,600. Contace Craig S. Suwinski, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, Michigan 48202.

THE MARQUETTE AREA physicians are seeking board certified or eligible Pediatrician with special interest and ability in neonatology for this growing community in Michigan's Upper Peninsula Designated Regional Special Care Nursery providing level 2-3 care. Opportunity to combine neonatology with general pediatric care in conjunction with area's other Pediatricians. Immediate opening created by established physician's return to university setting. Teaching opportunities with medical students and family practice residents. Send inquiries and curriculum to: John Wojcik, MD, Chairman, Recruitment Committee, Marquette General Hospital, 420 West Magnetic Street, Marquette, Michigan 49855. (906) 228-9440.

PSYCHIATRIST — to associate in practice in suburban northwest Detroit area. Terms negotiable. Contact Prem S. Prasad, MD, 32905 W. 12 Mile Road, Suite 310, Farmington Hills, MI 48018. Phone: 313/553-9822.

Positions Wanted

TRIAL ATTORNEY AVAILABLE — 24 years experience in criminal,civil, and Administrative Board cases — available to represent persons before the MICHIGAN BOARD OF MEDICINE. Address inquiries to : C. Michael Kimber, P.C., 402 Michigan Building, Detroit, Michigan 48226. (313) 965-1145.

Miscellaneous

ASPEN MUSHROOM CONFERENCE. Identification of edible, poisonous and hallucinogenic mushrooms. Treatment of mushroom poisoning. Microscopy. Novice and advanced courses. AMA Category I. July 29-Aug. 3, 1979. Wildwood Inn, Snowmass-at-Aspen, Colorado. Contact: Beth Israel Hospital, 1601 Lowell Blvd., Denver, CO 80204. (303) 825-2190 ext. 550.

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Area health education centers need good leaders, communication, cooperation

By Robert Sherefkin
***Special to* Michigan Medicine**

What single piece of advice would the directors of Michigan's existing community medical education corporations give communities considering such a corporation today.

That was the question posed to a panel of the seven Michigan area health education corporation (AHEC) directors at a discussion sponsored recently in Grand Rapids by the Michigan Association for Medical Education (MAME).

Leading the discussion was MAME program co-chairman Robert K. Richards, PhD, Ann Arbor.

"Picking solid leaders is a must," answered Thomas J. Cinque, MD, director of medical education, Saginaw Cooperative Hospitals, Inc. These people will be dealing with the pressures and with many funding agencies, and this requires a special director, he said.

Geraldine Purcell, executive director, Southwestern Affiliated Hospitals of Flint, said she would advise that any such program be a "grass roots program to the consortium of health agencies, instead of the other way around."

"You need good communication to formulate good policy," she added.

Executive Director of Graduate Medical Education Inc., John C. Newton, said a clear relationship of the three partners in health care — medical staff, trustees and administration — should be established if a successful health education center is to be formed.

Robert Nicholson, MD, executive director of the Southwestern Michigan Area Health Education Center, said he is prepared to establish an AHEC in a rural or other medically underserved area. "The big thing is to gain the cooperation and interest of the community," he said.

The AHEC concept, Richards said, began with the 1970 Carnegie Commission report and followed as a "logical way to put together all the training resources of an area and link them with the training needs of an area."

However, he said, neither the Carnegie Commission's vision of an AHEC nor the AHEC legislation had as significant an influence on Michigan's community medical education corporations as Michigan State University's College of Human Medicine did.

The relatively youthful Michigan State University College of Human Medicine (MSU-CHM) has proven to be a major influence on many community medical education corporations. This community-based medical school has chosen to conduct its educational programs by contracting with educational corporations in many communities, according to Richards. The chief executive officer for the corporation is also MSU-CHM's community assistant dean, Richards added.

He said in several communities the association with MSU-CHM for medical student education has now grown to encompass joint residencies in certain specialties and collaborative relationships in CME efforts.

Richards said other community corporations have evolved independently of an MSU-CHM relationship, with these corporations developed solely to meet community needs such as to conduct multi-institutional training programs.

On the subject of university medical school participation in the development of a successful community corporation, Ernest Hammel said both groups contribute to each other. Hammel, executive director of the Oakland Health Education Program, said medical school cooperation gives AHECs clinical teaching support. "The AHECs have a lot to contribute to the medical school. We can have AHECs without medical schools, but not enriched AHECs."

The effect of an era of cost containment and the development of AHEC's was a concern of several directors. "We are holding the line (on costs) reasonably well," Hammel said. "We are creatures of the hospital and must do what the hospitals are doing — we must be reflective of their cost containment."

Hammel said AHEC's may offer some economies of scale, and by cutting back on duplication between individual hospitals, "we may be able to demonstrate cheaper ways of doing several kinds of educational activities, but not all kinds."

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HANCOCK HOUGHTON AREA — Office space is available immediately for interested physicians, 2300 sq. ft. in a 6 yr old building with 50 space parking lot with utilities and janitorial service included, office has own lab, emergency room and waiting room. Located 4 blocks from Portage View Hospital in Hancock. Contact Paul G. Goodreau, MD, 906/482-1839 or Leonard Beesley, DDS, 906/482-8602, at 1111 Hecla Street, Hancock, MI 49930.

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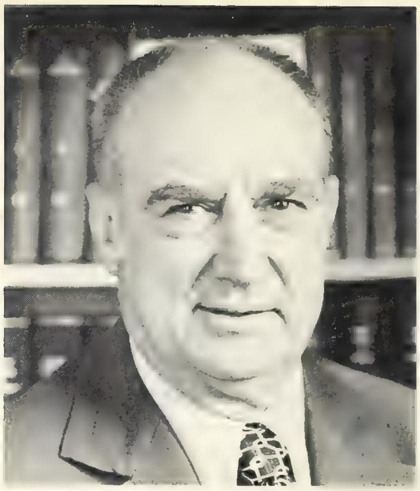
President's page

Physicians must lead a reform in medical cost containment



Ernest P. Griffin, Jr., MD
MSMS President

As your president, I want to share with you my thoughts on cost containment. I first expressed them before the 1979 House of Delegates, and I will present them in segments over the next few months through these *Michigan Medicine* president's pages.

This could be medicine's final call. If we fail to step forward and lead the battle, the present system of the practice of medicine in the United States will be destroyed. And, as you know, this is the finest system in the world today. Physicians are responsible for the advanced state of medical care in this country. We may not have invented or discovered every new procedure, but we have developed its application to medicine.

Needed treatment

All other systems of medical practice can only exist by limiting access to the patient that needs treatment.

This fact has been proven by experience in the United Kingdom. It has been reported in *The New York Times* that several thousand Britons with kidney disease will not receive dialysis due to the decision of the National Health Service not to spend $10,000 annually for their treatment.

In a recent report to the AMA, the Canadians have shown that they are rapidly approaching the same state of affairs as a result of their federal government trying to impose a reduction in active treatment beds by the use of fiscal constraints.

In the United States, AMA Vice-President James Sammons, MD, has said, "The proposed National Health Plan appears to have one central paramount theme: The containment of health care costs through the creation of a federally-controlled health system. We are concerned about the approach because such controls carry the threat of health care rationing."

The problem is enormous, and physicians do not have the expertise or authority in all of the areas that are involved. It has been calculated that less than one-half of the total cost of health care is under the control of physicians.

We must recognize this and enlist the aid of many segments of society. The key to the solution is proper application of the knowledge that we now have.

The AMA moved in the right direction with its cross-sectional select committee which recommended methods of cost containment, but it completely missed many of the causes of the present cost crisis. Physicians on the committee engaged in self-flagellation and allowed the lay members to heap more coals on the fire.

Some 29 times, the AMA committee delineated things physicians should do, many of which were not within our power. Only on three vague points did they concede that society has anything to do with the high cost of medical care. We can no longer permit society to shift its deficiencies to the medical profession.

If cost containment continues in its present direction, physicians will be the ultimate target. They will suffer the consequences and those equally responsible for the problem will walk away.

HEW has determined physicians receive directly less than 19 cents of each dollar spent on care. The physician's portion of medical care costs is not the prime reason for the present climate.

Michael Halberstam, MD, Washington cardiologist, and editor of *Modern Medicine*, points out that we have always known medicine is expensive, but it took American actuarial know-how to translate every sniffle into dollars and cents. He further observes that disease cost money in 1900, but it was a personal and not a governmental issue.

He continues, "What has made the cost of treating illness into a political rather than a personal issue is the fact that we are increasingly responsible for each other's medical costs. . ."

Accept responsibility

We have accused everybody of driving up the cost of medical care and it is warranted. But we have refused to realistically accept our own responsibility. Therefore, for the protection of ourselves and this great medical system, we must accept the challenge and lead a reform.

Physicians have tremendous knowledge in many broad areas, but we must enlist knowledgeable people in specific, critical areas. It is obvious that the present situation involves all segments of society and will require realistic involvement of all to solve the problem. With physician input, much can be accomplished.

(Next month, a statewide program for cost containment involving six segments of society.)

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

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In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative

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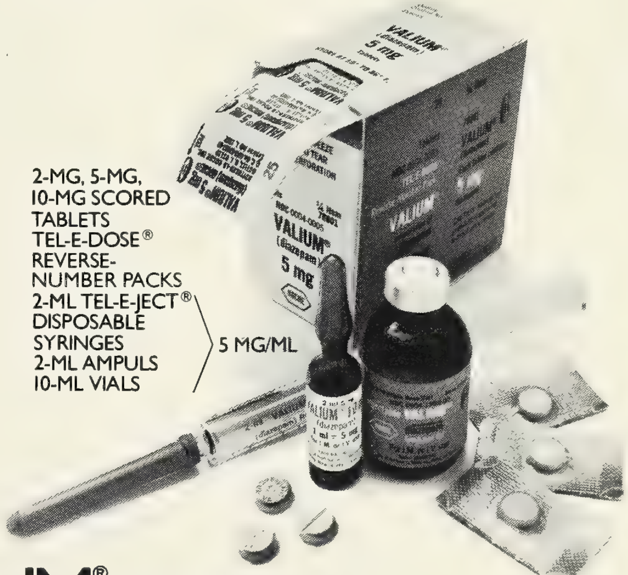

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BREAKING NEWS FOR MICHIGAN DOCTORS

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VOL. 78, NO. 18 JUNE 22, 1979

INSIDE THIS ISSUE is a list of all 1979 MSMS Annual Scientific Meeting courses planned to date. The big three-day meeting is scheduled November 13-14-15 at the Hyatt Regency, Dearborn. Be sure to check the list and begin to make plans to attend those courses of your choice. Registration and housing reservation forms will follow in future issues.

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CAPSULES

LEGAL COUNSEL FOR MSMS continue to negotiate the language of a proposed FTC order. This language would probably have a significant impact on physician ability to have meaningful input into the development of health care plans of third party payors, including Blue Cross/Blue Shield of Michigan. It is hoped that the FTC will change the proposed Order to allow for such input.

* * *

JACKSON-AREA STATE POLICE ask MSMS members' help through the June issue of Michigan Medicine. They present an X-ray of unusual surgery performed on a person whose body was found in the area some time ago but who has not been identified. Please check page 340 of the June issue and notify the police if you recognize the X-ray.

* * *

FREE SECOND SURGICAL OPINIONS will be available to Medicaid receipients in Wayne, Oakland and Macomb counties beginning July 1. The Department of Social Services has contracted with Blue Cross/Blue Shield of Michigan to

(cont. back page)

BCBSM reform now under study by solons, health cost coalition

Legislation to reform Blue Cross/Blue Shield of Michigan, and to impose insurance commissioner regulations on reimbursement to providers, has been referred to a crash summer study project by the House Insurance Committee. It had become apparent there was no concensus yet on the legislation. The Health Care Cost Containment Coalition, composed of the Big Three auto makers, the UAW, AFL-CIO and BC/BSM,(chaired by Jack Shelton, manager of employee benefits for Ford Motor Co.), will attempt to recommend to the Legislature a program of reform and cost containment by Sept. 11. The coalition is substantially the same as that which drafted Michigan's hospital bed reduction program in 1977-78. The coalition will deal primarily with how legislation and state government can effect a cost containment program in delivery of medical care. MSMS has offered cooperation to the coalition in its study, and in turn has been invited to advise the coalition on physicians' viewpoints on cost containment. The matter now lies before the MSMS Council for discussion July 6-7.

MSMS testifies on State Health Plan; won't officially support or oppose

MSMS cannot support or oppose the proposed state health plan for 1979-1983, testified MSMS government liaison staff member Sherry N. Wellman June 11. She spoke on behalf of MSMS State Legislation and Regulations Committee Chairman W. E. Maldonado, M.D. before the combined Senate Committee on Health and Social Services, and the House Committee on Public Health. MSMS supports the plan's call for expansion of services to increase accessibility and quality of health care, she said, but must ask how such expansion can be taken seriously when another portion of the plan says health care expenditures should not exceed the level of 1977. MSMS testimony did praise the state's establishing health care planning priorities and did reiterate MSMS' commitment to playing an active role in health planning. The state health plan is called for by the State Health Planning and Resources Development Act and was prepared by the Statewide Health Coordinating Council.

1979 MSMS Annual Scientific Meeting offers 56 courses at Hyatt Regency Dearborn

All courses will be for three hours of category I credit.

November 13
Tuesday Morning (8:30 to Noon)

- "Alpha-Omega Session: Overview of Pulmonary Diseases in Children, Adults and Elderly Patients." *Director: Samuel M. McMahon, MD, Michigan State University College of Human Medicine and Ingham Medical Center.*

- "Cancer Prevention: Practical Medicine for the Family Physician." *Director: Michael J. Brennan, MD, Detroit. Sponsored by Michigan Cancer Foundation.*

- "Diabetes — The State of the Art." (Part I) *Director: George L. Royer, Jr., MD, Kalamazoo. Sponsored by MSMS Section on Clinical Pharmacology.*

- "Hematology for Non-Hematologists." *Director: Carter R. Bishop, MD, Wayne State University School of Medicine.*

- "Industrial and Environmental Pollutants." *Director: Denis F. Cash, MD, GM Parts Division, Flint. Sponsored by Michigan Occupational Medicine Association.*

- "New Concepts in Evaluation and Treatment of Stroke Syndrome." *Director: James I. Ausman, MD, Department of Neurological Surgery, Henry Ford Hospital.*

- "Preventing Physician Suicide Through Early Recognition and Proper Care." *Director: Douglas A. Sargent, MD, Grosse Pointe Farms. Sponsored by MSMS Committee to Assist Impaired Physicians.*

- "What's New in Office Gynecology." *Director: R. Ralph Margulis, MD, Department of Obstetrics and Gynecology, William Beaumont Hospital.*

Tuesday Afternoon (1:30 to 5:00)

- "Alpha-Omega Session: Birth and Death of the Endocrine System." *Director: David R. Rovner, MD, Department of Medicine, Michigan State University College of Human Medicine.*

- "Basic Cardiac Life Support." *Co-Directors: Ann L. Harwood, MD and Eugene C. Grochowski, MD, Butterworth Hospital, Grand Rapids. Sponsored by Michigan Chapter, American College of Emergency Physicians.*

- "Common Errors in ECG Interpretations." (Wet Clinic) *Director: Franklin E. Hull, MD, Department of Medicine, Wayne State University School of Medicine.*

- "Diabetes — The State of the Art." (Part II) *Director: George L. Royer, Jr., MD, Kalamazoo. Sponsored by MSMS Section on Clinical Pharmacology.*

- "Gastrointestinal and Pulmonary Endoscopy: A Review." *Director: James E. Mayle, MD, Department of Medicine, Michigan State University College of Human Medicine.*

- "Management of Chronic Low Back Pain." *Director: James M. Bullock, MD, Ingham Medical Center, Lansing. Sponsored by Michigan Occupational Medicine Association.*

- "Neurological Problems for the Primary Physician." *Director: Oliver D. Grin, Jr., MD, Grand Rapids. Sponsored by Michigan Association of Neurological Surgeons.*

- "Practical Approach to Electrolyte Problems." *Director: Nathan W. Levin, MD, Division of Nephrology, Henry Ford Hospital.*

- "Sports Medicine for Primary Care Physicians." (Wet Clinic) *Co-Directors: Gerald A. O'Connor, MD, Ann Arbor, and William T. Davison, MD, Port Huron. Sponsored by Michigan Orthopaedic Society.*

- "The Use of CAT-Scan in Making a Diagnosis Economically." *Director: E. James Potchen, MD, Department of Radiology, Michigan State University College of Human Medicine.*

- "Use of Psychoanalytic Knowledge in Medical Practice." *Director: Lawrence P. Tourkow, MD, Southfield. Sponsored by Michigan Psychoanalytic Society.*

November 14
Wednesday Morning (8:30 to Noon)

- "Advanced Cardiac Life Support." (A Provider Course to run all day Wednesday and Thursday.) *Co-Directors: Ann L. Harwood, MD and Eugene C. Grochowski, MD, Butterworth Hospital, Grand Rapids. Sponsored by Michigan Chapter, American College of Emergency Physicians.*

- "Alpha-Omega Session: Urological and Renal Diseases." *Director: Joseph C. Cerny, MD, Henry Ford Hospital, Detroit. Sponsored by Michigan Branch, American Urological Association.*

- "Diagnosis and Treatment of Chronic Ear Disease for Primary Care Physicians." (Wet Clinic) *Director: Sean B. Peppard, MD, Department of Otolaryngology, Wayne State University School of Medicine.*

- "Management of Gastrointestinal Bleeding." *Director: John P. Papp, MD, Grand Rapids. Sponsored by Michigan Society for Gastrointestinal Endoscopy.*

- "Management of Premalignant Breast Disease." *Director: Robert M. O'Neal, MD, University of Michigan Medical School. Sponsored by Michigan Academy of Plastic Surgeons.*

- "New Respirators and Techniques for Treating Respiratory Failure." *Director: John G. Weg, MD, Pulmonary Division, University of Michigan Medical School.*

- "Office Dermatology for the Non-Dermatologist." *Director: Thomas F. Downham, II, MD, Taylor. Sponsored by Michigan Dermatological Society.*

- "Pediatric and Adolescent Gynecology." *Director:*

onald T. Olson, MD, Detroit. Sponsored by Michigan ociety of Obstetricians and Gynecologists.

- "Physician Role in Cost-Effective Medical Care." Direcor: R. Jack Chase, MD, Grand Rapids. Sponsored by SMS Committee on Medical Care Costs.
- "Stresses Within the Physician's Family." Director: Gail arton, MD, Ann Arbor. Sponsored by the Michigan sychiatric Society and the MSMS Auxiliary.
- "What's New in Allergy and Asthma in Children." Diector: John A. Anderson, MD, Henry Ford Hospital, Deroit. Sponsored by the Michigan Allergy Society and the ichigan Chapter, American Academy of Pediatrics.
- "What's New in Antibiotics and Common Office Infecions." Director: A. Martin Lerner, MD, Department of edicine, Wayne State University School of Medicine.

ednesday Afternoon (1:30 to 5:00)

- "Alpha-Omega Session: Hematuria." Director: Gerald F. onway, MD, Royal Oak. Sponsored by Michigan Branch, merican Urological Association.
- "Bronchial Asthma in Adults: Diagnosis and Manageent." Director: Timothy A. Smith, MD, Saginaw. Sponored by Michigan Allergy Society.
- "Cutaneous Manifestations of Systemic Disease." Direcr: Thomas F. Downham, II, MD, Taylor. Sponsored by ichigan Dermatological Society.
- "Doctor, Why Did You Cancel My Case?" Director: aylord D. Alexander, MD, Sinai Hospital, Detroit. Sponored by Michigan Society of Anesthesiologists.
- "Inflammatory Bowel Disease." Director: John M. Maceigan, MD, Ferguson Clinic, Grand Rapids. Sponsored y Michigan Society of Colon and Rectal Surgeons.
- "Nuclear Medicine — Its Practical Value." Director: arlene Fink-Bennett, MD, Royal Oak. Sponsored by ichigan College of Nuclear Medicine Physicians.
- "Otolaryngological Diseases: Latest Advances in echnique and Management." Director: John W. Grigg, D, Bay City. Sponsored by Michigan Otolaryngological ociety.
- "Psychological Problems of Critically-Ill Patients." Diector: Sumer Verma, MD, Department of Psychiatry, ichigan State University College of Human Medicine.
- "Psychology of Abortion." Co-Directors: Ruth Day, MD, t. Clair Shores and Linda Logsdon, MD, Southfield. ponsored by Michigan Psychiatric Society.
- "Reconstruction Following Mastectomy." Director: obert M. O'Neal, MD, University of Michigan Medical chool. Sponsored by Michigan Academy of Plastic Sureons.
- "What's New in Common Pediatric Problems." Director: eorge H. Baker, MD, Department of Pediatrics and uman Development, Michigan State University College Human Medicine.
- "What's New in Evaluation of the Dizzy Patient." Director: Eugene Rontal, MD, Wayne State University School of Medicine.

November 15
Thursday Morning (8:30 to Noon)

- "Controversies in Medicine: Treatment of Coronary Artery Disease." Director: Subhash C. Khullar, MD, Wayne State University School of Medicine.
- "Diagnosis and Management of Monoarticular Arthritis." Director: Jose L. Granda, MD, Department of Medicine/Division of Rheumatology and Clinical Immunology, Wayne State University School of Medicine.
- "Examination of the Eye." (Wet Clinic) Director: Frederick W. Bryant, MD, Royal Oak. Sponsored by Michigan Ophthalmological Society.
- "Medical Ethics Workshop." Director: Andrew Hunt, MD, Medical Humanities Program, Michigan State University College of Human Medicine. Sponsored by MSMS Task Force on Medical Ethics.
- "New Concepts in Congestive Heart Failure." Director: Park W. Willis, III, MD, Michigan State University College of Human Medicine.
- "Preventive Cardiology — The Primary Care Mission." Director: Albert W. Sparrow, MD, Department of Human Development, Michigan State University College of Human Medicine.
- "Understanding and Treating Alcoholism and Drug Dependence." Director: Richard C. Bates, MD, Lansing.

Thursday Afternoon (1:30 to 5:00)

- "Current Concepts in the Medical and Surgical Management of Ischemic Heart Disease." Director: Agustin Arbulu, MD, Department of Surgery, Wayne State University School of Medicine. Sponsored by Michigan Chapter, American College of Chest Physicians.
- "Drug Therapy in Rheumatic Diseases." Director: Jose L. Granda, MD, Department of Medicine/Division of Rheumatology and Clinical Immunology, Wayne State University School of Medicine.
- "Imaging Use in Clinical Medicine." Director: Albert A. MacPhail, MD, Flint. Sponsored by Michigan Radiological Society.
- "Office Diagnosis and Management of Eye Movement Disorders." Director: James W. Klein, MD, Detroit Institute of Ophthalmology. Sponsored by Michigan Ophthalmological Society.
- "Ventricular Premature Beats: Their Significance and Current Therapy." Director: Sidney Goldstein, MD, Henry Ford Hospital, Detroit. Sponsored by Michigan Chapter, American College of Physicians.
- "What's New in Treatment of Hypertension." Director: Charles P. Lucas, MD, Wayne State University School of Medicine.

provide the second opinion service in hopes of cutting costs. The primary physician will not be notified of the second opinion, if the patient so requests. The decision to have surgery remains with the patient.

* * *

WITH THE ADDITION of David Laytner to the MSMS/Physician Service Group, Inc. consulting staff, physician office computer studies and in-office practice management consultations are now available. Mr. Laytner has years of experience in medical office practice management, and is well qualified to help with important decisions regarding computers, personnel, patient flow, accounting and scheduling.

Also, the PSG announces the endorsement of I.C. System, Inc., a company offering the highest standard in professional collections efforts. The service is personalized, localized, and effective. The rates are far below the competition and the collection rate compares favorably to existing services. For further information, please contact John Anthony, general manager, MSMS/Physician Service Group, Inc., 517-337-1351.

Brown-McNeely Fund, relicensure, Medicaid budget acted upon

The Michigan legislature has set a July 15 deadline for adjournment. It is acting rapidly on many fron

...The Senate has taken final action on legislation to extend the Brown-McNeely state medical malpractice insurance fund one year, to July 1, 1980. A 33-to-0 vote sent the bill, introduced by Rep. Matthew McNeely, to the governor, who is expected to sign the bill into law before the fund expires this year. In House action on the bill, Rep. McNeely stated this is the last extension for the fund, and he expects private and commercial malpractice insurance companies to absorb Brown-McNeely within the year.

...On June 19 the Joint Administrative Rules Committee approved the Department of Licensing and Regulation's proposed triennial licensure procedure for physicians. MSMS testified in support of the triennial system, as it coordinates nicely with the three-year CME reporting period.

...The Medicaid budget, with $139 million for physician fees, has passed the House. The Senate is now holding hearings.

MPMLC lowers rates, simplifies sys

The Michigan Physicians Mutual Liability Company announced three new developments in an Immediate Action News Bulletin mailed to physicians throughout the state on June 12.

*A simplified application for professional liability insurance will be in use through Aug. 15. This short-form application makes it easy to obtain a premium quote and apply for coverage.

*All specialties will benefit from a 5% rate decrease which will take effect July 1.

*Surplus Certificates may now be purchased under an interest free installment payment plan. For additional information call 1-800-292-1926(toll free) or 517-351-1150.

Michigan State Medical Society
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East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine

Medigram

VOL. 78, NO. 19 JULY 13, 1979

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CAPSULES

OF KEY MSMS INTEREST as the legislature ended its spring session July 15 were the Medicaid appropriations bills. House and Senate were meeting in conference committee after the Senate had allowed significantly more Medicaid funding than the House in separate bills. The Senate also proposed second surgical opinion screening for selected elective prodedures to contain medical costs, a measure MSMS favors over the House's proposal for prior authorization of hospital admissions. Both House and Senate Medicaid appropriations included $1 line items for non-therapeutic abortions.

PHYSICIANS ARE ENCOURAGED to keep their calendars open for Oct. 24, when the MSMS State Legislation and Regulations Committee has scheduled its second annual Public Affairs Conference for Michigan physicians and other interested health professionals. The all-day event will be at Long's Convention Center, Lansing. Speakers will include Cong. Dave Stockman, and Walter McClure, PhD, a medical economist. The fee will be $15. Further details will appear in Medigram.

AMONG NEW PEOPLE at MSMS headquarters are the following:
- Robert T. Stanziano, East Lansing, director of financial services for the MSMS/Physicians Service Group. Mr. Stanziano joined the new MSMS/PSG staff in April. He formerly was Vice President and senior trust officer with Michigan National Bank and on the staff of Lansing Community College.
- Kevin A. Kelly, new staff of the MSMS Physician/HSA Support Center. Mr. Kelly received his degree in economics from MSU in March, and was employed by the Michigan Mid-South HSA.

MSMS Council highlights

At its July 7 midsummer meeting, the MSMS Council:

1) Adopted a working document on medical costs to be used by the MSMS Task Force on Legislative Cost Containment Proposals. The paper basically states cost awareness programs can be successful only by educating society in the impact of health care decisions.

2) Resolved to take steps to ensure MSMS' advice to the Health Care Cost Containment Coalition led by Jack Shelton which is working at the request of the legislature to recommend a cost containment program by Sept. 11. The coalition was formed after introduction of proposed legislation to reform Blue Cross/Blue Shield of Michigan.

3) Approved Practical Guide #5 for Cost Savings in Surgery, drawn up by the MSMS Task Force on Medical Care Costs. The new guide will be distributed to county medical societies and hospital chiefs of staff.

4) Supported greater concern and a more active role by MSMS in the membership of the Michigan Board of Medicine.

5) Approved a contract between MSMS and the MSMS/Physician Service Group, Inc., to allow the PSG to provide custodial services for the MSMS creative reserve and capital reserve funds.

MSMS suggests EMS advisory group

The Michigan Department of Public Health appears amenable to the suggestion of an MSMS ad hoc committee that an advisory committee be convened to discuss emergency room categorization criteria. No formal response has been received yet by the MSMS ad hoc committee, chaired by Brooker L. Masters, MD. The committee said categorization of hospital emergency rooms is valuable for health planning and management, but the current criteria fail to acknowledge the realities of rural hospitals.

MAJOR SPECIALTIES PLANNING ANNUAL SCIENTIFIC MEETING COURSES

Nearly every major specialty society in Michigan is planning at least one course during the 1979 MSMS Annual Scientific Meeting Nov. 13-14-15 at the Hyatt Regency Dearborn. A total of 56 courses offering three hours of Category I credit each are planned. Two full days of advanced cardiac life support again are scheduled, and full days are offered in diabetes, industrial medicine, asthma, dermatology, pediatrics, urology, otolaryngology, ophthalmology, plastic surgery. A broad range of courses will be available in pulmonary diseases, psychologic aspects of illness and body imaging techniques and instruments. A full list of courses was printed in the June 22 Medigram. Further information is available from Sherry Fent at MSMS headquarters.

Doctors Coury and Potchen seeking election at AMA annual

John J. Coury, MD, will be a candidate for re-electi to the AMA Board of Trustees when the AMA House of Delegates convenes for its annual meeting July 22-26 in the Chicago Marriott Hotel. The Michigan delegation will be sponsoring Doctor Coury for a second three-year term on the AMA board. Doctor Coury was first elected in 1976, and has risen in the board to appointment as chairman of the AMA Finance Committee. Doctors Richard L. McMurray of Flint and Frank B. Walker of Grosse Pointe are Doctor Coury's co-managers. Also from Michigan, E. James Potchen, MD, chairman of the Department of Radiology, Michigan State University College of Human Medicine, is a candidate nominated by the AMA Board to the Council on Medical Education. Doctors David Siegel of Lansi and Thomas R. Berglund of Kalamazoo are co-managers for Doctor Potchen. Robert Hunter, MD of Sedro Woolley, Wash., current chairman of the AMA Board, i an uncontested candidate for president-elect. Among the more than 60 resolutions the House of Delegates will consider are five submitted by Michigan at the direction of the MSMS House. Robert E. Rice, MD, Greenville, is chairman of the Michigan delegation.

MSMS Council working for good Board of Medicine candidates

The MSMS Council has intensified its search for phy- sicians who will seek appointment to the Board of Medicine. Complications in Board of Medicine procedures subject to the new Public Health Code have heightened the need for doctors who can contribute sufficient time to the job--an average of four days a month. In an effort to bring MSMS closer to the needs of the board, leaders from MSMS and the Board met July 11 for a broad-ranging discussion of the changes on the board and the prerequisites required of board members.

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MICHIGAN MEDICINE

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Editor: Judith Marr

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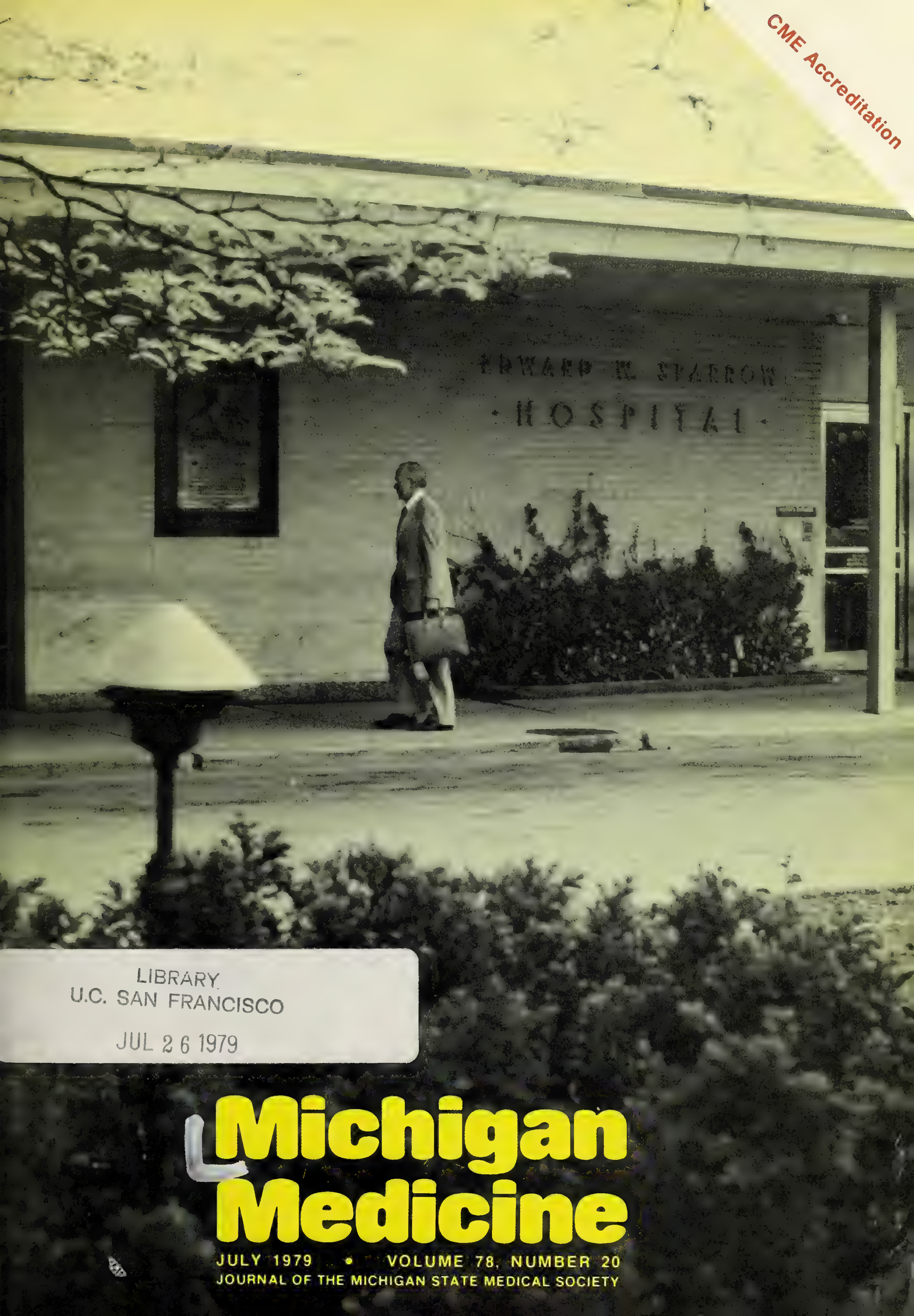
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CME Accreditation

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JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

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Contents

July 1979

Michigan Medicine

Special Section

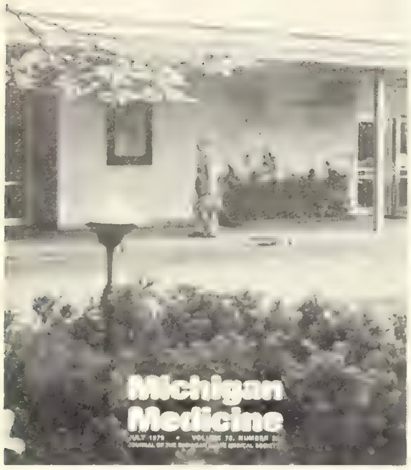
359 The MSMS CME Accreditation Committee is a major link in approving Michigan organizations and institutions for providing Category I CME courses. See articles beginning on facing page.

Features

364 MSMS computers available to keep hospitals' CME records; Richard Garlick
368 Photos of the 1979 MSMS House of Delegates meeting
373 MSMS Annual Scientific Meeting to feature "wet clinics"
386 Medical schools add cost awareness to curricula
392 AMA jail health standards may become mandatory in Michigan; Jeffrey L. Eubank
395 Legislation seeks Michigan health service corps; Willah Weddon
396 Profile of AMPAC board member Thomas Berglund, MD; Charles Downs
398 Detroit's Tel-Med one of most popular; Shelton Reece
400 Health care top priority of Kellogg Foundation
402 WCMS bylaws changes strengthen hospital staffs' position; Roger Mecum

Departments

366 Meetings
374 MPMLC clipsheet
376 MSMS/A; Anita Yannitelli
378 MSMS Q/A
380 Letters
385 News; Katie Brewbaker
388 Category I courses
397 Views; Joseph E. Kincaid, MD
404 Classified Ads
405 Ad index
406 President's Page; Ernest P. Griffin, Jr., MD



Among the MSMS CME Accreditation Committee's major activities are site visits to hospitals seeking approval to present Category I courses. On the cover, Roland G. Hiss, MD, Ann Arbor, committee member, makes a site visit. There's more on the Accreditation Committee beginning on the facing page.

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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MSMS committee plays vital role in Michigan CME accreditation process

By R. W. Pomeroy, MD
Lansing

We Michigan physicians control the direction of the complex system which provides physician-produced continuing medical education programs in the state.

If we wish to have hospital CME programs considered for Category I relicensure credit, we may do so by having our institutions or organizations appropriately surveyed and accredited. If we wish to have Category II programs, we apply on an individual program basis to the Michigan Board of Medicine.

And in each CME area, the MSMS Committee on CME Accreditation plays a vital role. To help MSMS members better understand the role of the committee, and its relationship to other CME organizations, this article provides details of the accreditation process.

CME has been an integral part of physicians' lives since the days of Hippocrates. In 1975, however, CME in Michigan received new emphasis when state legislation required a specific number of CME hours for annual medical relicensure. The Michigan Board of Medicine is the CME controlling agency for Michigan. This board has adopted the essential standards of the Michigan State Medical Society CME Committee, which are modified slightly from the AMA (now LCCME) standards. Because of the Board's many other

(Continued on page 362)

Doctor Pomeroy is chairman, MSMS Committee on CME Accreditation.

Categories merely indexing system; they do not suggest course quality

Category I CME programs seem to be greatly over-emphasized in the minds of most Michigan physicians, as they appear to think Category I is of better quality than Category II or other categories.

This is not the case, however, as the difference is only in their method of course development.

We all recognize other forms of CME (such as a hallway consultation or our own reading) can be more meaningful and productive than a lecture. The numerical ranking is not a quality ranking; it merely is an indexing system.

Category I programs by definition are organized, planned programs and must be sponsored (produced) or cosponsored (shared production) by a hospital or organization which has had an appropriate survey and meets seven specified standards to become accredited.

The Category I program itself must be based on five specified criteria. Category II programs need not meet these criteria and must be approved on an individual basis by the Michigan Board of Medicine.

In Michigan, Category I CME programs are considered only as educational programs designed by and for practicing physicians and concerned with health care of the patient. Residency programs are not allowed Category I classification.

An approved (accredited) hospital or organization may certify its programs as of Category I stature if the following program criteria are met to satisfaction:

1) The program is based on identified educational needs concerned with health care.
2) The program has stated learning objectives.
3) The program is based on these learning objectives.
4) The program has an evaluation to see if the objectives were met.
5) The program has a readily retrievable and meaningful attendance record.

Although educational terminology is used in the criteria, it is essentially the same system that a physician uses in his daily practice with patients: —RWP

CME Criteria	**Patient practice**
Needs identification	**Diagnoses**
Objectives	**Expected results of treatment**
Organized program based on objectives	**A treatment program based on these expected results.**
Evaluation	**Was the treatment successful?**
Records	**Data for review regarding methods used and their success or failure.**

Excellent Alma CME program underway for 20 years

By Victor V. Rozas, MD
Alma

Novelty, scientific curiosity and improved patient care have been the driving forces behind a successful program of continuing medical education at Gratiot Community Hospital in Alma.

The Alma program was established 15 years before continuing medical education became mandatory.

The program earned four years' accreditation in 1978 for its excellence and is a fine example of a small community hospital program accredited by the MSMS Committee on CME Accreditation.

The Alma program's early origins were due to a need felt by some hospital staff members for further education close to home. Key among them were Keith Stackhouse, MD, general surgeon, and Carlos Philippon, MD, pediatrician. Their programs proved to be so interesting and informative that staff members' enthusiasm has not flagged.

The weekly conferences regularly attract about 80 percent of the medical staff and find common grounds between general practitioners and specialists.

The program has been maintained with minimal supportive staff, without a budget until two years ago, and strictly on a voluntary basis. Detailed minutes, records of attendance, and even a medical brief of each program have been kept dating back to the beginning. They are on file now for handy reference.

Among recent programs have been a discussion of polymicrobic infections and new antibiotics by the director of the division of infectious diseases at Ohio State University, and a presentation by three Gratiot physicians of an interesting case of primary hyperparathyroidism.

Fall, spring clinics

Each spring and fall, the Gratiot Community Hospital CME program sponsors day-long clinics which draw physicians from a wide area. The fall program is aimed at the family physician, while the spring clinics are presented on a rotating basis with the Mt. Pleasant-based Central Michigan Community Hospital.

A well-maintained core library including Index Medicus has facilitated literature search.

A journal club also has met weekly without interruption. Uninhibited and lively discussions are stimulated by self-criticism of the presenting physician; thus, physicians are more open in offering constructive criticism and this "open conversation" has prompted continuing physician interest.

Introducing and reviewing knowledge have been the main objectives of the Gratiot Community Hospital program. Other benefits include the opportunity to get members of the staff together and to facilitate communication among them with an "informal" exchange of ideas extending beyond the classroom. Consultations, comments and self-generation of more topics to discuss have been frequent "spin-offs."

The addition of new specialists to the medical staff and requirements for accreditation of the continuing medical education program have necessitated some changes in the educational administrative structure of the program.

The committee overseeing CME has been strengthened with representatives from the individual departments, with major responsibilities to the committee chairman.

The educational committee has responsibilities for the CME program and the library, a satisfactory combination for a small hospital. Membership and chairmanship is on an overlapping, rotating basis. The present chairman has been in charge since 1975.

A modest budget has allowed improvement in audio-visual materials, the creation of a fund for guest speakers, and the services of a part-time secretary. The CME Committee meets on a quarterly basis, setting objectives and goals which are purposely kept flexible.

Needs determination

One of the noteworthy aspects of the Alma program is the method of determining physicians' educational needs.

At one time an informal method, it now features a four-point system which includes annual surveys of all staff members and of staff departments, periodic reports by the medical record/audit and emergency care committees, literature review by specific assignment to staff members, and review of the evaluations of the previous years' programs.

The CME program chairman gets a "rating" of each individual conference. Although a formal card rating system is employed, individual comments are held more valuable because they are not confined to a rigid "happiness index."

Doctor Rozas is chairman of the CME committee at Gratiot Community Hospital, Alma.

Lansing family physicians have their own CME program

By Gary Gillespie, MD
Lansing

A physician attending CME meetings presented by the Family Practice Department at E. W. Sparrow Hospital, Lansing, should gain two things:

1) A solid core of knowledge to assist him in his practice, and

2) Improved skills necessary to provide high-quality continuing care for his patients.

The Sparrow Family Practice Department has created a CME program which provides a good example of those accredited around the state by the MSMS CME Accrediting Committee. At the same time, it is a good example of a unique program structured primarily for physicians of one specialty to meet their particular recertification needs.

The goal of the Sparrow Family Practice Department's CME meetings is to assist and stimulate physicians to review the core content of family practice every three years. Thus it is hoped the practicing physician's knowledge, skills and attitudes will be maintained and improved.

Satisfy state and AAFP

Board-certified family physicians must meet state requirements for relicensure, and the requirements of the American Academy of Family Physicians to maintain the right to sit for the re-certification examination required every six years. Our departmental conferences have helped to satisfy the requirements of both the State of Michigan and the Academy.

Sparrow Hospital is a community hospital with a stong commitment to teaching residents and medical students. It has been approved to certify CME programs for credit by the MSMS CME Accrediting Committee and by the Liaison Committee on Continuing Medical Education (LCCME).

The format for our family practice conferences was conceived by the departmental CME committee, which includes the director of medical education for the hospital as well as representatives from the active staff of our department. All planned conferences must meet the approval of the hospital CME committee in order to qualify for CME hours.

In 1976, the committee determined its department members' needs by reviewing surveys of the departments of family practice at the University of Michigan and the University of Kentucky and by surveying our own department members for their needs based on local practice and experience. This information yielded a list of 17 broad subject areas. These were given a weighted value. A three year program was established to present one subject per month, with two months a year set aside for optional programs to allow for flexibility to changing educational needs.

The three-year structure was selected to coincide with the three-year framework of the Michigan Academy of Family Physicians (MAFP) membership requirements, and with the three-year AMA Physicians Recognition Award. It was also viewed as a reasonable length of time for reviewing the family practice core content. The three-year format also coincides with the three-year family practice residency program of our hospital.

Interaction between our family practice residents and practicing physicians is encouraged in the planning of individual conferences. A practicing physician is selected on a rotating basis from the departmental active staff as the individual responsible for each month's conferences. Working closely with him is a family practice resident.

The program chairman determines the format for the conferences which may be a panel presentation, workshop or lecture. Lecture format is by far the most popular. Speakers may be selected from other departments in the hospital, from the College of Human Medicine or other faculty of Michigan State University or the community at-large. The practicing physician may elect to present the conference and serve as principle speaker.

The staff physician and resident are required to submit a final list of speakers and specific conference topics at least three months in advance so that approval may be sought from the MAFP for prescribed credit, and from the CME Committee of the hospital.

Meet every Wednesday AM

The department meets routinely on Wednesday mornings for one hour. The first three Wednesdays are devoted to Category I programs, with the fourth Wednesday designated as a business meeting, for which no CME or MAFP credit is given. Each fifth Wednesday (generally four per year) is scheduled for a half-day, four hour credit program concerned with the subject of the month, with morning speakers and a luncheon panel discussion.

Our program has been functioning since January, 1977, and our monthly subjects and responsible staff physicians have been assigned through December 1982. In general, this program has met with satisfaction on the part of the practicing physicians and seems to be a workable system. A second perceived needs survey was done in August of 1978, and some shifting in program emphasis was made for the three year period of 1980-82.

Due to the program's three-year format, the busy practicing physician is allowed the opportunity to plan his postgraduate education well in advance. Supplements to the material presented in our conferences can be obtained through more extensive reading and other seminars and conferences.

Doctor Gillespie is chairman of the Family Practice CME Committee at E. W. Sparrow Hospital, Lansing.

CME ACCREDITATION/*Cont.*

These Michigan organizations are accredited to offer CME

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

- American Association for Hand Surgery, Warren
- American College of Emergency Physicians, Lansing
- American College of Psychiatrists, Southfield
- American Society of Colon and Rectal Surgeons, Detroit
- Ann Arbor Psychiatric Association
- Commission Professional and Hospital Activities, Ann Arbor
- Michigan Academy of Family Physicians
- Michigan Academy of Plastic Surgery
- Michigan State Medical Society
- Michigan State University College of Human Medicine, East Lansing
- Michigan Chapter, American Academy of Pediatrics
- Michigan Dermatological Society
- Michigan Heart Association
- Michigan Lung Association, Lansing
- Michigan Ophthalmological Society
- Michigan Society of Anesthesiologists
- Noah Worcester Dermatological Society, Detroit
- Section of Gastroenterology, American Society for Gastroenterology, Detroit
- University of Michigan Medical Center, Ann Arbor
- University of Michigan School of Public Health
- Wayne State University School of Medicine, Detroit

Hospitals:

- Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
- William Beaumont Hospital, Royal Oak
- Beyer Memorial Hospital, Ypsilanti
- Blodgett Memorial Hospital, Grand Rapids
- Bon Secours Hospital, Grosse Pointe
- Burns Clinic Med. Center, PC/Northern Michigan Hospitals, Inc., Petoskey
- Butterworth Hospital, Grand Rapids
- Central Michigan Community Hospital, Mt. Pleasant
- Chippewa County War Memorial Hospital, Sault Ste. Marie
- Community Health Center of Branch County, Coldwater
- Community Hospital Association of Battle Creek
- Cottage Hospital of Grosse Pointe
- Detroit-Macomb Hospital Association
- Dickinson County Memorial Hospital, Iron Mountain
- Ferguson-Droste-Ferguson Hospital, Grand Rapids
- Grace Hospital, Detroit
- Gratiot Community Hospitals, Alma
- Hawthorn Center, Northville
- Henry Ford Hospital, Detroit
- Heritage Hospital, Taylor
- Holy Cross Hospital, Detroit
- Hurley Medical Center, Flint
- Ingham Medical Center, Lansing
- Kalamazoo Regional Psychiatric Hospital
- Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
- Leila Y. Post Montgomery Hospital, Battle Creek
- Marquette General Hospital
- McLaren General Hospital, Flint
- Mecosta County General Hospital, Big Rapids
- Mercy Hospital, Port Huron
- Metropolitan Regional Psychiatric Hospital
- Midland Hospital Center
- Mt. Carmel Mercy Hospital & Med. Center, Detroit
- Munson Medical Center, Traverse City
- North Detroit General Hospital, Detroit
- Oakwood Hospital, Dearborn
- Pennock Hospital, Hastings
- Pontiac General Hospital, Pontiac
- Portage View Hospital, Hancock
- Port Huron Hospital CME Committee
- Providence Hospital, Saginaw
- Saginaw Cooperative Hospitals, Inc., Saginaw
- Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
- St. Francis Hospital, Escanaba
- St. John Hospital, Detroit
- St. Joseph Hospital, Flint
- St. Joseph Mercy Hospital, Pontiac
- St. Joseph Mercy Hospital, Ann Arbor
- St. Lawrence Hospital, Lansing
- St. Mary's Hospital, Grand Rapids
- St. Mary Hospital, Livonia
- Sinai Hospital of Detroit, Detroit
- Southwest Detroit Hospital
- Edward Sparrow Hospital, Lansing
- Traverse City Regional Psychiatric Hospital, Traverse City
- V.A. Hospital, Battle Creek
- West Shore Consortium, CME, Ludington/Hart/Manistee
- Ypsilanti Regional Psychiatric Hospital, Ypsilanti

DOCTOR POMEROY/*Cont.*

activities, it chose to work through the MSMS to accredit organizations.

In 1972 the physicians of Michigan established the original MSMS CME Commission, and among other things, charged that approved programs should have reciprocity with other states. This allows physicians to obtain some of their credit outside Michigan if they desire. But this only can be done through the AMA voluntary program which culminates in presentation of the Physicians Recognition Award (PRA). This meant that the Committee would be working under dual direction of (1) the Michigan Board of Medicine and, (2) the PRA national accrediting body, the AMA. The latter job now is handled by a committee known as the Liaison Committee for CME (LCCME).

The LCCME surveys and accredits organizations or hospitals whose programs may involve three or more states, i.e., universities and national organizations; it approves state bodies desirous of accrediting hospitals or organizations within their own states. In Michigan our MSMS Committee on CME Accreditation surveys institutions or organizations for accreditation.

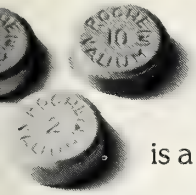
Briefly, then, in Michigan, the process is as follows:

- The legislature establishes the law.
- The Board of Medicine enforces it and promulgates specific rules.
- The MSMS Committee on CME Accreditation may recommend principles and guidelines to the LCCME and the board for Michigan approval.
- If approved, the institution or organization certifies its own programs for Category I through its own CME administrative process.

In summary, it should be repeated that once a hospital or organization is accredited, the Category I certification is its responsibility and is to be based on the five mentioned criteria (See accompanying article).

Please see related article, page 364.

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® ⓘⓥ
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

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MSMS computers available to keep hospitals' CME records

By Richard Garlick
Flint

Michigan's physicians need proof of CME attendance for relicensure. Therefore, a wide variety of attendance record cards, which also usually include an education evaluation, have been developed by the over 50 accredited institutions in Michigan.

The collection of this data represents a massive problem not only in evaluating individual courses, but also in keeping participants up to date on the number of hours earned.

The directors of medical education responsible for these records have found that for a secretary to develop and maintain them is extremely time-consuming and expensive. A computer is cheaper but hospital equipment is not always available for this purpose.

MSMS computer available

To assist in this record-keeping, the Michigan State Medical Society has made its computer available. Over the past several years, some hospitals have purchased these services on an individual basis and found them more economical than secretarial help.

Three types of reports need to be readily available: (1) the attendance record for each conference; (2) a verification of attendance for each physician on the hospital staff for the year, and (3) the evaluation of each conference.

Hurley Medical Center, Flint; Edward W. Sparrow Hospital, Lansing and St. Francis Hospital, Escanaba have been using the society's computer services as a method of analyzing data on the attendance and evaluation records.

A standardized reporting card was developed by a committee consisting of Richard W. Pomeroy, MD, Director of Medical Education at Edward W. Sparrow; Paul T. Werner, MD, chairman of the CME Committee at St. Francis Hospital, Richard D. Garlick, director of CME, Hurley Medical Center, and MSMS' Wayne Burmeister, manager, Department of Operations and Member Services.

The group agreed a five-point system would be meaningful, which would report the physicians's views of (1) The quality of information; (2) The improvement of the learner's understanding; (3) The value of the program to the learner's patient care; (4) The learner's improvement of knowledge and; (5) The quality of the presentation.

'Happiness index' recorded

These evaluations in various forms have become known as a "happiness index." They merely reflect the opinion of the individual at the time of the presentation.

Everyone recognizes this is not a good indication of the effect of the presentation on patient care, but rather reflects the individual's opinion as to how the program affects his practice. This index is certainly the most simple and meaningful technique we have at the moment. It is of value in interpreting immediate reactions of the audience.

Long-term results on patient care need to be evaluated by some other method. Further research is needed in the whole evaluation process in order to determine the effect of CME on practice of medicine.

The card being utilized by Hurley Medical Center requires attending and house officers only to fill in the date, speaker, sponsoring department, title, and M.E. number and sign their names after completing their evaluation. If a physician is not from Hurley, he completes the address and his evaluation is included in the report. Separate physician files are not kept on non-staff physicians. Instead, they are provided a certificate. If the program is accredited for more than one hour, this information is added. Cards are deposited in collection boxes located in the classrooms, picked up daily and mailed weekly to MSMS.

Two reports monthly

Two types of reports are provided on a monthly basis for each program: Attendance and evaluation of each physician and an analysis of each question by course. The analysis is particularly useful in judging the immediate response to the quality of the program. Each question is evaluated by attending physicians, house staff, and the combination of both. The information is provided to the speaker and the educational "chief". It is always good to receive a "3.5". But, if the speaker's grade is below "3.0" he has direct feedback to help him improve his lecture technique or other weakness.

On a quarterly basis the MSMS computer service provides an analysis of selected programs; in Hurley's case, Grand Rounds for Internal Medicine, OB/GYN, Pediatrics and Surgery; providing a running comparison of the quality of the program.

Also, on a quarterly basis for the first nine months of the CME reporting year and monthly for the last quarter, a print-out of individual physicians' attendance is provided. This regular update assists the physician in keeping track of the hours he has earned at Hurley towards meeting Michigan relicensure requirements.

The MSMS computer service provides information valuable in a number of ways. As more CME-accredited agencies utilize the service, the possibility of a central information bank becomes evident. A physician will be able to complete a program at any member location in the state, fill in a card and have his attendance credited to his home file. By having a state-wide system of record-keeping, the individual costs should decrease through better utilization while the overall quality of programs should be improved through analysis of performance.

Mr. Garlick is director of Continuing Medical Education, Hurley Hospital, Flint.

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

The still-functioning geriatric can benefit from Hydergine treatment

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Oral Hydergine tablets promote better patient compliance

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Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
Before prescribing, see package insert for full product information.

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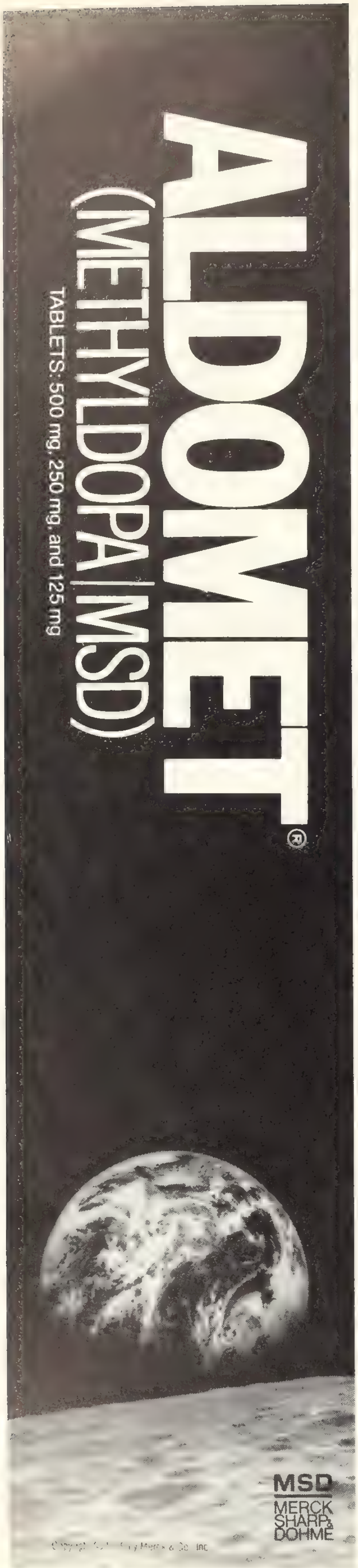

Meetings

Of MSMS, AMA, medical assistants

July 21-22 — American Association of Medical Assistants, Summer Seminar, Sugar Loaf, Cedar, contact: Helen Schulte, MSMS headquarters.

July 22-25 — AMA-Auxiliary National Convention, Chicago, contact: Helen Schulte, MSMS headquarters.

July 22-26 — AMA Annual Meeting, Chicago Marriott Hotel, contact: AMA headquarters, 312/751-6000.

Aug. 10-11 — Institute for Salaried Physicians: Dynamics of Conflict Resolution, Denver, contact: AMA Department of Negotiations, 535 North Dearborn St., Chicago, 60610, or 312/751-6645.

Aug 27-Sept. 1 — AMA Special Joint Session on Medical Staff Leadership and Conflict Resolution, Wentworth-by-the-Sea, Portsmouth, NH, contact: AMA Department of Negotiations, 312/751-6647.

Sept. 12 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24 — MSMS Conference on State Legislation, contact: Bruce Ambrose, MSMS headquarters.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters, 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

July — Institute of Gerontology Continuing Education Seminars, Teaching/Learning Communities in Neighborhood Setting (July 9-11), Drama and Literature Programs for the Elderly (July 9-11), Activity Programs for the Elderly (July 12-13), Music Therapy in Treatment Settings for the Elderly (July 14), Agency Administration: Fiscal Management (July 23-25), Counseling Older Adults and Their Families (July 23-27), Teaching of Aging in Community and Educational Setting (July 23-27), contact: Dorothy Coons, Institute of Gerontology, Wayne State University, 313/764-3493.

Aug. 8 — Emergency Services Deployment Seminar, Wayne State University, contact: Joanne Juhl, Wayne State University, 313/577-4707.

Sept. 23-26 — Toxic Substances in the Human Food Chain: Implications for Public Health Practice, University of Michigan Extension Service, Radisson-Cadillac Hotel, Detroit, contact: Jane Elgass 313/764-5307.

Michigan Physicians Mutual Liability Company Announces

5%

Premium Decrease Across the Board Effective July 1, 1979

In this age of double-digit inflation, it is truly remarkable to find a product whose price is falling. This 5% MPMLC rate decrease follows a 2.2% decrease which took effect January 1, 1978.

Despite inflation, MPMLC has not once increased rates since it began writing insurance three years ago.

Congratulations to the Michigan physicians who had the foresight to establish their own insurance company — who chose not to rely upon a temporary governmental remedy to the medical malpractice problem.

MPMLC Where Physicians Make The Difference

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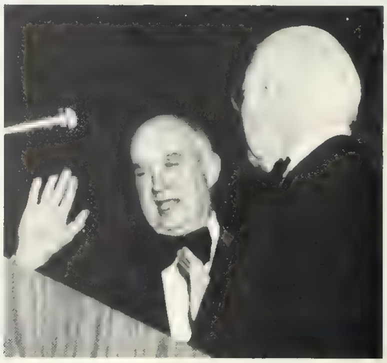
KALAMAZOO CENTER

With the aid of a penlight during the darkened ceremonies, new MSMS President Ernest P. Griffin Jr., MD, second from left, received the mantle of MSMS leadership from Louis E. Heideman, MD, right, 1978-79 president. Assisting in the ceremony were MSMS Secretary Robert M. Leitch, MD, left, and Speaker of the House James D. Fryfogle, MD.

Photo highlights, of 1979 MSMS House of Delegates

John R. Ylvisaker, MD, Pontiac general surgeon, was chosen president-elect by the delegates. His term will begin in May, 1980.



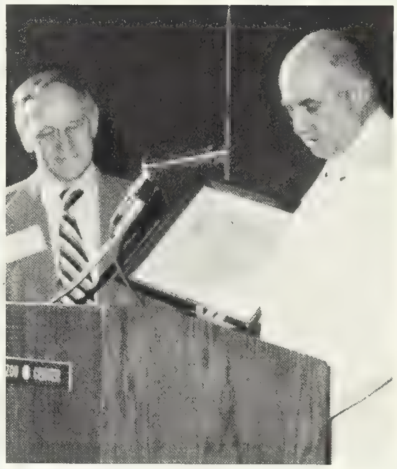
Doctor Griffin, Flint radiologist and former MSMS Council chairman, took the oath of office during the House of Delegates ceremonies. The Kalamazoo Hilton was the site.

The delegates considered and rejected the Blue Cross/Blue Shield proposal for a cost containment system. That and a $60 dues increase were among the delegates' most significant activities. They acted upon 69 resolutions in the three-day meeting.

During special ceremonies to honor physicians graduated 50 years ago from medical school, these former MSMS officers were recognized. They are, from left, Harold "Dutch" Meier, MD, Coldwater, former MSMS Council chairman; D. Bruce Wiley, MD, Lansing, past MSMS secretary; Harold Hiscock, MD, Flint, past MSMS president, and Robert J. Mason, MD, Oxford, (Maryland), past MSMS president.

MSMS Auxiliary fund-raising efforts in conjunction with the AMA Educational Research Fund culminated at the House of Delegates meeting with the presentation of checks to the state's three medical schools. On hand to accept the donations earmarked for the University of Michigan Medical School was George R. DeMuth, MD, associate dean. Presenting the checks were, from left, Mrs. Leland C. Brown, Mt. Clemens, Michigan AMA-ERF chairman; and Mrs. Edward Weddon, Stockbridge, 1978-79 MSMS/A president.

The annual Michigan Doctors Political Action Committee luncheon during the Kalamazoo meeting featured a membership award presentation by Tom Norton, left, American Political Action Committee director; and an address by Cong. Howard Wolpe (D-Lansing), center. State Sen. John Welborn (R-Kalamazoo) also spoke. At right is MDPAC Chairman Thomas C. Payne, MD, Lansing.



Special recognition was given by the delegates to Herbert A. Auer, left, MSMS employee for nearly 20 years and deputy director at the time of his resignation in January. Mr. Auer is now executive vice president of the Michigan Health Council.

At the 1979 MSMS House of Delegates meeting in May, elections changed the officer roster. Here is the new list:

MSMS officers

MSMS leaders

Ernest P. Griffin Jr., MD, Flint, *President*
John R. Ylvisaker, MD, Pontiac, *President-elect*
Robert M. Leitch, MD, Battle Creek, *Secretary*
Leland E. Holly II, MD, Muskegon, *Treasurer*
James D. Fryfogle, MD, Southfield, *Speaker, MSMS House of Delegates*
David Siegel, MD, Lansing, *Vice Speaker*
Louis E. Heideman, MD, Birmingham, *Immediate Past President*
Louis R. Zako, MD, Dearborn Heights, *Chairman, MSMS Council*
James H. Tisdel, MD, Port Huron, *Vice Chairman*
Robert E. Rice, MD, Greenville, *Chairman, AMA Delegation*

Councilors

C. Jackson France, MD, Harper Woods
Carl A. Gagliardi, MD, Lincoln Park
Benjamin Jeffries, MD, Harper Woods
Marion G. McCall Jr., MD, Detroit
Louis R. Zako, MD, Dearborn Heights
First District
Justin L. Sleight, MD, Lansing
Second District
William D. Walters, MD, Battle Creek
Third District
Thomas R. Berglund, MD, Portage
Fourth District
Harvey M. Andre, MD, Grand Rapids
Fifth District
Richard L. Rapport, MD, Flint
Sixth District
James H. Tisdel, MD, Port Huron
Seventh District
Robert J. Toteff, MD, Saginaw
Eighth District
Vickers C. Hansen, MD, Manistee
Ninth District
Charles L. Oppy, MD, Roscommon
Tenth District
Robert E. Paxton, Fremont
Eleventh District
Busharat Ahmad, MD, Marquette
Twelfth District
William S. Jones Jr., MD, Menominee
Thirteenth District
Dean P. Carron, MD, Ann Arbor
Fourteenth District
Frederick W. Bryant, MD, Royal Oak
Orville Oughtred, MD, Mt. Clemens
Fifteenth District

Tenuate® ⓒⅣ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

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References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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April 1979

UPJOHN MOTRIN

Physicians at MSMS Annual Scientific Meeting will learn to use new equipment, techniques

Doctor, how about some CME courses in which you actually take part in group discussions of ECGs you study at close hand, learn to tape an athlete as a team physician, or learn to use the latest endoscopic equipment and techniques?

Each of these learning experiences will be available to you at the 1979 MSMS Annual Scientific Meeting planned Nov. 13-14-15 at the Hyatt Regency Dearborn.

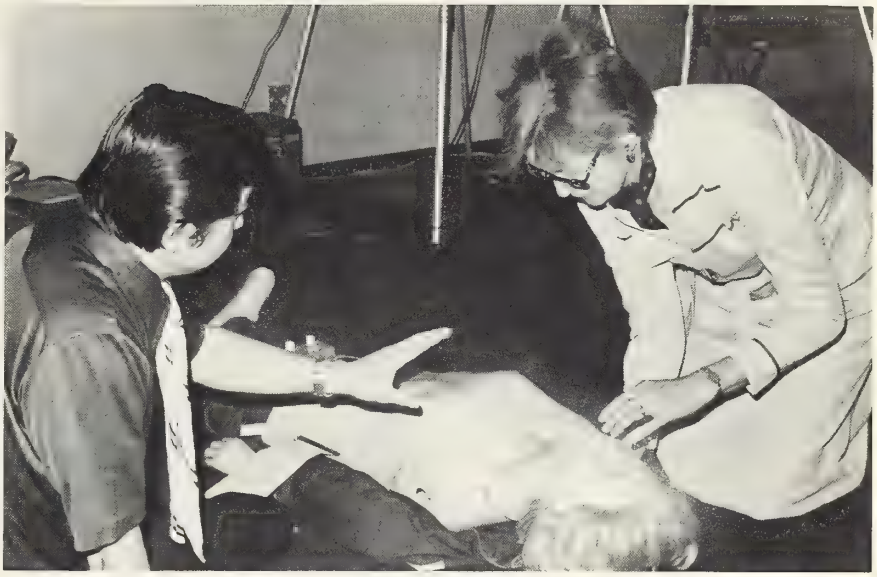
There are seven "wet clinic" type courses planned by Annual Scientific Meeting Chairman Samuel M. McMahon, MD, Lansing. (A full list of courses appeared in the June 22 *Medigram* newsletter. Registration forms and hotel reservation information will follow early in September.)

Doctor McMahon has urged all course directors to take the "wet clinic" approach, which uses presentation of real patients, hands-on demonstrations, and participation by students, as opposed to the more formal lecture presentation.

He based his urgings on the success of the advanced cardiac life support classes held during each of the three preceding Annual Scientific Meetings, and also upon physicians' comments during previous meetings, when they called for more demonstration and less lecture.

The Annual Scientific Meeting planning committee already had been approached by Michigan ophthalmologists, who planned to demonstrate and help physician/students learn how to examine the eye. Frederick W. Bryant, MD, Royal Oak, is director of that course.

Another example is the course on "Neurological Problems for the Primary Physician," which will feature a dialogue between Course Director Oliver D. Grin, Jr., MD, Grand Rapids, and a nurse-clinician who suffered with abnormalities of the back.



An advanced cardiac life support class from an earlier MSMS Annual Scientific Meeting.

Other "wet clinic" sessions planned will be the advanced cardiac life support course, co-directed by Ann Harwood, MD, Grand Rapids, and Eugene Grochowski, MD; "Common Errors in ECG Interpretations," Franklin Hull, MD, Detroit, director; "Diagnosis and Treatment of Chronic Ear Diseases for Primary Care Physicians," Sean Peppard, MD, chairman; "Gastrointestinal and Pulmonary Endoscopy: A Review," J. E. Mayle, MD, director; and "Sports Medicine for Primary Care Physicians," Gerald A. O'Connor, MD, Ann Arbor, director.

The Annual Scientific Meeting this year is being geared to the primary care physician, and most courses will award both Category I and American Academy of Family Physicians prescribed credits. A total of 18 credits may be earned during the three-day meeting.

The 56 courses scheduled for the Tuesday-Wednesday-Thursday meeting make the MSMS Annual Scientific Meeting one of the largest state society-presented CME functions in the country.

The expanded Hyatt Regency will offer even better facilities than those appreciated by MSMS members at the 1976 and 1977 scientific meetings. Exhibitors also will be on hand to offer detailed information on their products to the physicians who visit their booths.

Assisting Doctor McMahon with the planning are members of the Annual Scientific Meeting Advisory Committee: Edward Cotton, MD, Marcellus; Frank Cox, Jr., MD, Detroit; Thomas F. Downham II, MD, Taylor; Kenneth Krabbenhoft, MD, Detroit; David R. Rovner, MD, East Lansing; James C. Stanley, MD, Ann Arbor, and Joan C. Stryker, MD, Detroit. MSMS staff person in charge is Sherry Fent, coordinator of CME programming.

Working with the advisory task force for the 1979 Scientific Meeting are members of the CME Programming Committee, headed by Carl F. Hammerstrom, MD, Marquette.

For further information, please contact Sherry Fent at MSMS headquarters, 120 W. Saginaw, East Lansing, 48823. Telephone 517/337-1351.

MPMLC Clipsheet

MPMLC cuts rates by five percent

This article is fifth in a series intended to better inform Michigan doctors about the Michigan Physicians Mutual Liability Company and its activities.

Mid-June marked the start of a 60-day easy enrollment period at MPMLC. Physicians all over the state have received a short-form MPMLC application to assist them in taking advantage of this opportunity. MPMLC advises physicians to return completed applications immediately to meet the special enrollment deadline of Aug. 15.

Physicians are sure to welcome two other changes at MPMLC this summer:

- MPMLC surplus certificates may now be purchased on an interest free installment plan.
- A five percent rate decrease which benefits all specialties took effect on July 1. This is MPMLC's second rate decrease in just three years of operations. A prior 2.2 percent overall decrease took effect Jan. 1, 1978.

For details, please contact MPMLC at:

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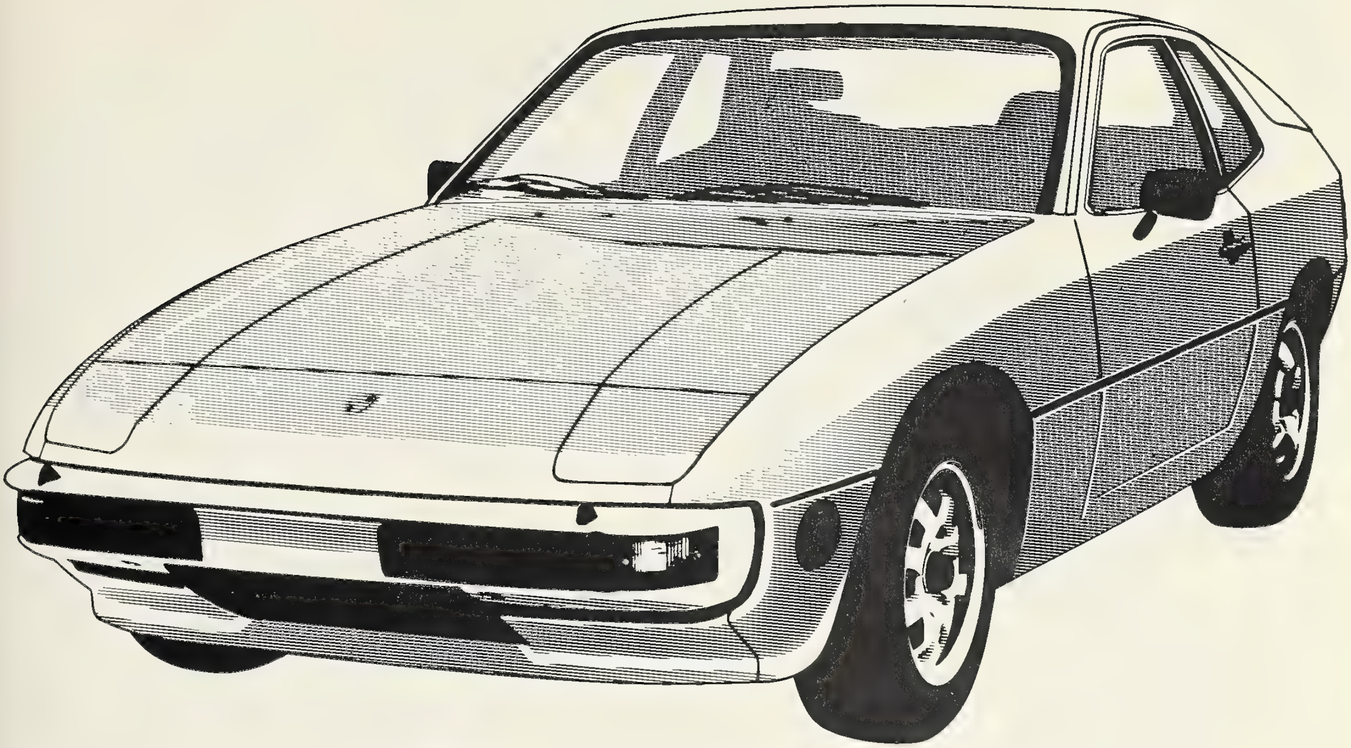

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MSMS/A

Auxilians cap their year with annual convention in May

By Anita Yannitelli
Battle Creek

The 53rd annual convention of the Michigan State Medical Society Auxiliary (MSMS-A), held in Kalamazoo's Sheraton Inn May 4-6, was a fitting climax to a year of increasing cooperation with the medical society.

Kalamazoo is the site of MSMS-A's inception. Caroline B. Crane, MD, called a group of doctors' wives together here in 1926 and from this meeting emerged the auxiliary. Membership has increased to nearly 3,000 since that time and goals have broadened. Today's purposes are to actively assist the state medical society, to coordinate county auxiliaries and to cultivate friendly relations and promote mutual understanding among physicians' families.

The "Kalamazoo Konfab" furthered and enriched these goals. Physicians as well as Auxilians were invited to participate in a pre-convention tour of the Upjohn Company. The auxiliary's board meeting began Friday evening, approximately the same time as the MSMS House of Delegates, to allow husbands and wives to make the trip together. The Sunday afternoon adjournment was also timed to coincide as closely as possible. Members of the Kalamazoo Academy of Medicine Auxiliary worked tirelessly for months toward the success of the meeting.

Louis Heideman, MD, MSMS president, delivered the keynote address to Auxilians; Dennis Paradis, director of the MSMS Physician/HSA Support Center, familiarized auxilians with Health Systems Agency board meetings (HSA) and told them how they could help the medical society; Herb Auer, executive vice-president of the Michigan Health Council, told members how "Health Day" May 22, could be of value to the medical profession; and Mrs. Manuel Bergnes, AMA-Auxiliary president, outlined ways to increase membership and explained the importance of numbers in relation to influence.

Warren Tryloff, director, and the staff of MSMS, assisted in coordinating plans for the conventions. As a result, Doctors Heideman, Louis E. Zako, Council Chairman, and Ernest Griffin, newly installed MSMS President, were guests at various auxiliary functions. Mrs. Bergnes and the MSMS-A president were guests at the MSMS Installation dinner, and auxilians also attended.

During the past year the medical society invited the auxiliary to cosponsor a course during the MSMS Annual Scientific meeting, invited the MSMS-A president to attend a Council meeting, endorsed an MSMS-A column in *MICHIGAN MEDICINE* and seated an auxilian on the MSMS Impaired Physician Committee. These have been "firsts" and most appreciated.

Meanwhile, the continued financial support and the invaluable assistance provided by Helen Schulte and the MSMS Special Services Office have made it possible for the auxiliary to carry on many projects to assist the Medical Society.

Theme of the auxiliary this year has been, "We are all in this together." Let us continue that way.

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MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

Mr. Mehler

FOR: Herbert Mehler, East Lansing
MSMS Department of Economics and Finance

"How do I become a member of a PSRO board in Michigan?"

Any licensed practicing physician is entitled to become a member of a Professional Standards Review Organization. There are no dues or membership fees and a PSRO cannot refuse an interested physician. To become a board member, an MD must become a participating member and be elected. Boards vary in size from 12 to 35 members and selection processes vary, too. A Michigan physician may become a PSRO member by contacting the office of the local PSRO. It is particularly important that physicians in sophisticated specialties join PSROs, to assure representation of their views on the boards.

Mr. Paradis

FOR: Dennis Paradis, East Lansing
MSMS Department of Government Relations,
and drafter of EMS legislation

"Does MSMS support the current move for categorization of hospital emergency rooms? I understand this is being sought by the Michigan Department of Public Health, which has proposed categorization criteria.

MSMS does support hospital emergency room categorization, and the MSMS Ad Hoc Committee on EMS categorization criteria, chaired by Brooker L. Masters, MD, Baldwin, has sought comments from physicians around the state. They will pass on the comments to the MDPH as it works to perfect the criteria. Physicians' comments have revealed concern among rural hospitals that the proposed standards will be too difficult to put into effect.

Mr. Scholten

FOR: Mert Scholten, East Lansing
MSMS Chief of Communications

"I have heard there are physicians in Michigan specializing in bariatrics. What exactly is that field?"

Bariatrics is the study and treatment of weight control. There is an American Society of Bariatric Physicians with headquarters in Englewood, CO. The recognition of bariatrics as a subspecialty comes before the AMA House of Delegates from time to time, but the delegates so far have ruled bariatrics not sufficiently developed to be rated as such.

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Letters

More on CME

"... revoke these ridiculous requirements."

I would like to express my complete agreement with the views of Doctor Richard Wetzel regarding the CME ripoff being forced on physicians (May *Michigan Medicine*, p. 256). The amount of time being wasted in nonsense CME programs is a real crime. It is about time the federal and state governments realize the great percentage of the CME courses have developed into money-making propositions for medical schools and certain private organizations.

As a professional, I find it highly insulting to be forced to account for each hour of post-graduate training, and verify on a yearly "report card" form. I don't have to have an outside agency tell me it is important to keep up with advances in medicine. This concept was taught in medical school and during post-graduate training, and I have always taken sufficient courses to satisfy mandatory requirements. I object to being forced to account for a responsibility incumbent upon all physicians.

There are many CME programs that wind up being significant moneymakers, and I am sure some of the tuition fees are being used to supplement salary incomes and add to respective department coffers. Therefore, the registrant is indirectly subsidizing that program. As a member of the Michigan Dermatology Society, I am amazed at the amount of time being spent on the administrative aspects of continuing medical education by the CME Committee of the Society. These individuals are spending many hours doing purely administrative work, and frankly, I think it is a waste of time.

I certainly hope other physicians will heed Doctor Wetzel's plea in urging the MSMS to revoke these ridiculous requirements.

Earl J. Rudner, MD
Southfield

"Perhaps reducing . . . credits required . . ."

MSMS members were invited to send their view point to *Michigan Medicine* about the mandatory CME law in Michigan. Therefore, I wish to make the following comments:

Mandatory CME credits to maintain a license to continue to practice medicine are unjust and unfair since this is the only profession singled out for this purpose. Other professions such as dentists, lawyers, nurses and a host of others should be included in this mandatory law. I realize some of the professions such as the medical assistants are requiring CME credits to keep their certification up to date and perhaps others will follow. However, this is not yet included in the law.

This situation has reverted to an economic one involving high fees to attend the necessary meetings required for the credits, together with the added cost of transportation, food and lodging in addition to the time lost being away from the office and patients.

I have found that the medical reviews are stimulating and worthwhile but I object to being forced to attend meetings in order to retain my license to practice my profession.

Because of my age and general health situation I have discontinued doing surgery and must limit my office practice to doing only the work I feel qualified to do. I find it difficult to attend many meetings as required by this new law.

Retirement would be completely unacceptable to me and I am sure there are others who share the same feeling. Perhaps reducing the number of CME credits required for physicians over 65 should be considered.

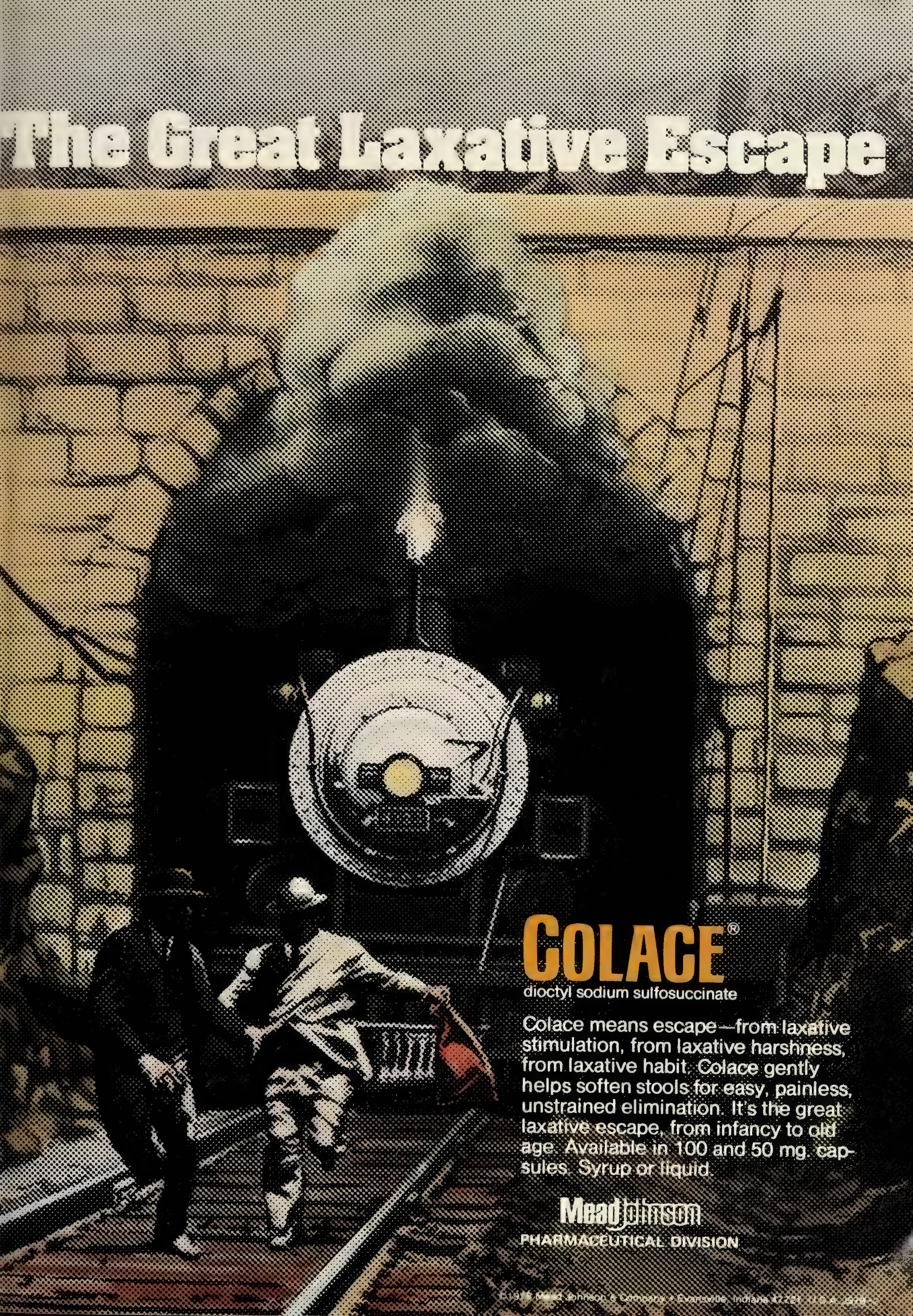
S. E. Andrews, MD
Kalamazoo

"... thank you for including this (CME folder) with the bulletin."

I just wanted to comment on the continuing education record book the society has sent to us (April 23, 1979 *Medigram*). I think this is a very appropriate document which gives us a reminder of our record situation and it is a very convenient device in my office to continually keep track of these particular hours of credit. I wanted to thank you for including this with the bulletin and I hope that this can continue on an annual basis as this seems very appropriate to our needs.

Thomas R. Peterson, MD
Ann Arbor

(Editor's note: The CME record-keeping file folder described above by Doctor Peterson is available free of charge from MSMS headquarters. It features information about CME requirements, as well as a form for at-a-glance listings of hours earned. Certificates of attendance may be filed inside the folder.)



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1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml

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See package insert for complete prescribing information.

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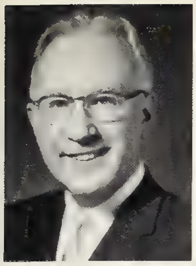
Mr. Burns

Doctor Lilly

Doctor Mainwaring

Doctor Ryan

By Katie Brewbaker, MSMS staff

Wm J. Burns, MSMS executive director from 1935 to 1964, was honored recently by the House of Delegates of the American Pharmaceutical Association at its annual meeting in Anaheim, California. Mr. Burns was presented a sterling silver plaque "in recognition of 20 years dedicated service as APhA Director of Exhibits." In making the presentation, President Jacob W. Miller commented that the APhA exhibit had a growth of over 400 percent since Mr. Burns had been invited in 1960 to organize "a fourth dimension in continuing education."

Recipient of a distinguished service award at the Wayne State University School of Medicine commencement exercises was **Jack Ryan, MD**, Sterling Heights. Doctor Ryan was recognized for his position as annual fund drive chairman of the Medical Alumni Association.

MSMS Councilor **Busharat Ahmad, MD**, Marquette, is a Paul Harris Fellow of Rotary International. Doctor Ahmad is one of only two Marquette Rotarians to ever receive this top Rotary award.

The newly-elected president of the Wayne State University School of Medicine's Alumni Association is **Burt T. Weyhing, III, MD**, of Grosse Pointe Farms.

A grateful community paid tribute to its physician and friend, **Roger Untalan, MD**, when the Crystal Falls Lions Club named him 1979 Citizen of the Year. At a sell-out banquet in his honor his fellow workers and grateful patients expressed their thanks and appreciation to "this most meritorious doctor, fine citizen and great humanitarian."

Gerald M. Schmit, MD, Ann Arbor, has been named the first medical director of Mercywood Neuro-Psychiatric Hospital. Doctor Schmit had been on the staff of Mercywood for 10 years prior to assuming this new post.

After 37 years of service as a physician and confidant to his patients, **Doctor Jerrian VanDellen**, East Jordan, has announced his retirement. Doctor VanDellen, who has spent 30 of those years with the Grandvue Medical Care Facility, will be recognized for his service to the community at a special party being held in his honor at the facility.

Robert P. Lilly, MD, is new president of the Detroit Surgical Society. President-elect is **John M. Hartzell, MD.** The association also has voted to change its name to the Southeastern Michigan Surgical Society.

The May 28 issue of *Newsweek* carried in its Medicine section a quote from **Richard C. Bates, MD**, Lansing, regarding some mass-screening programs, which reads in part, "These organizations have volunteered to examine little pieces of my patients without my permission . . . They have nibbled away at the intimate, primary-care relationship we have enjoyed."

Lawrence J. Sell, MD, Manistique, has been named chairman of the Northern Michigan University Board of Control, for a two-year term. Doctor Sell previously served as vice-chairman of the governing body.

WSU School of Medicine Clinical Professor of Psychiatry, **Emanuel Tanay, MD**, presented two papers and taught an all-day seminar at the recent annual meeting of the American Psychiatric Association in Chicago. Topics covered by Doctor Tanay were pseudo-political terrorism, inter-spouse abuse, and homicide and forensic psychiatry.

Rosser L. Mainwaring, MD, is recipient of the Wayne State University School of Medicine's Distinguished Alumni Service Award. The Dearborn pathologist is honored for his accomplishments in both the practice and teaching of pathology.

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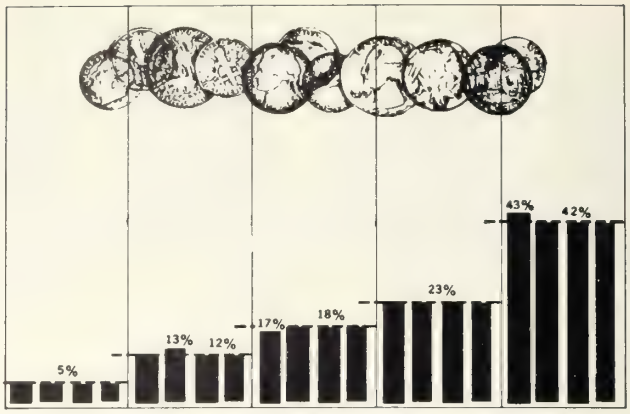


Cost awareness being added to med schools' curricula

Medical costs are going somewhere besides up at Michigan's three medical schools. They're going into the curriculum.

As subject matter for medical students, cost factors will be introduced on an experimental basis in the coming semester at the University of Michigan Medical School, according to Jane Schutz, assistant dean for curriculum, U-M.

Wayne State University School of Medicine, according to Charles Whitten, MD, associate dean for curricular affairs, anticipates introduction of cost issues by September.

Plans are furthest underway, however, at Michigan State University College of Human Medicine, where a project to introduce rigorous treatment of cost-effectiveness issues has received a $54,810 grant from the National Fund for Medical Education.

Cost-effectiveness issues at the College of Human Medicine will be centered in an important sequence known as "Focal Problems." This multidisciplinary course, team-taught by basic biological and behavioral scientists and faculty physicians, uses a combination of self-instruction and small-group discussion of a graded series of exercises to help students develop their skills in medical problem solving.

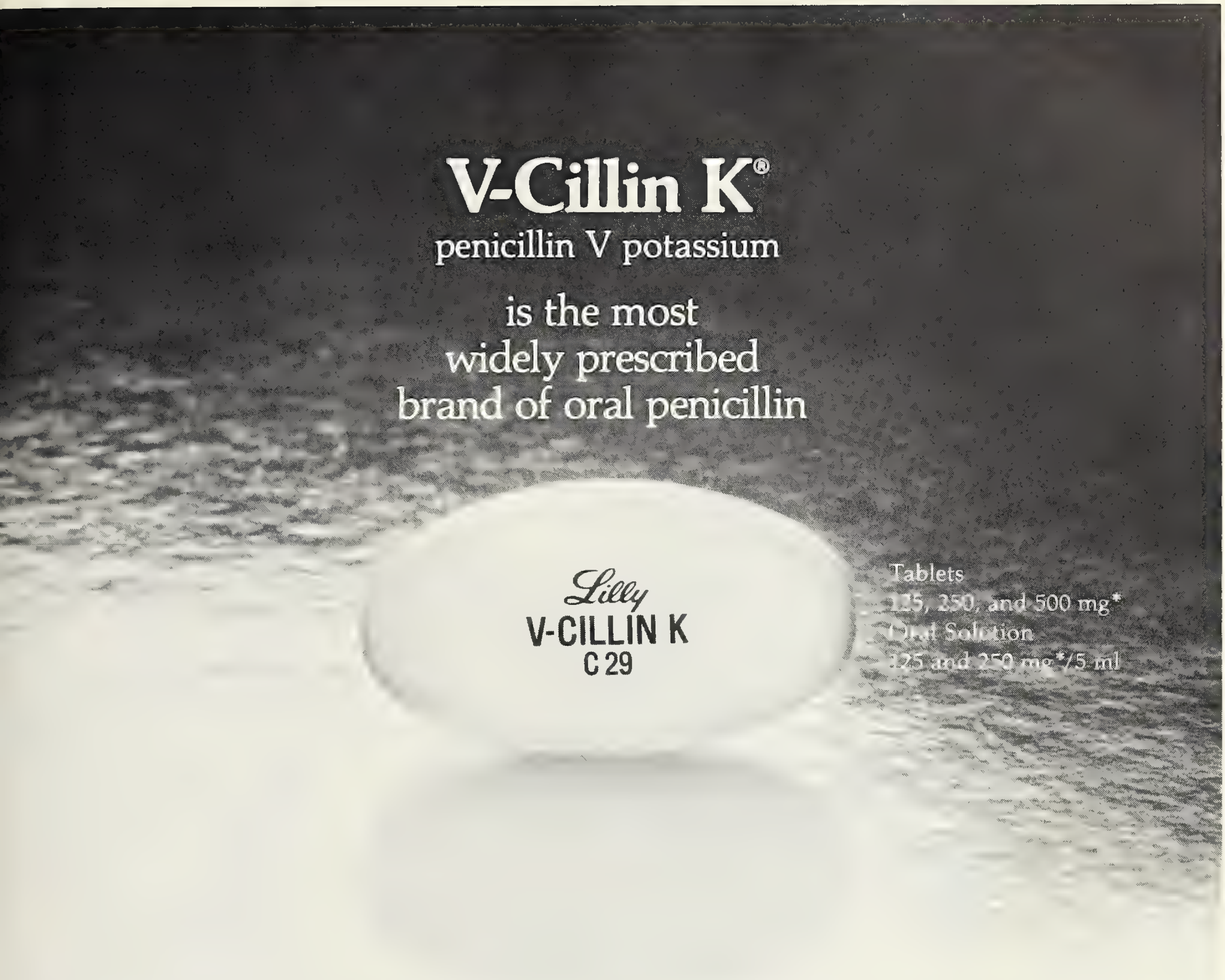
By introducing methods used in cost-effectiveness analysis, medical students can see how these methods can be applied by clinicians in providing patient care, administrators believe. This analysis helps to structure a patient problem, and to identify the probable costs and benefits of alternative courses of action.

"With the nation's yearly health bill close to $200 billion and studies showing that physicians control a majority of that expense," said Arthur F. Kohrman, MD, director of the cost-effectiveness project, "introducing curriculum material on costs and cost-effective decision making is a significant approach to better control of escalating health costs."

Doctor Kohrman said the principles of decision theory will be applied to show medical students examples of decision points where they, as physicians, can control costs or where external regulation is now contemplated as a means of holding down costs.

Appropriate readings and discussion questions will be developed so that discussion groups can devote time to considering the cost-containment issue and the physician's role in it.

Usefulness of the materials to be developed will not be limited to undergraduate medical education, Doctor Kohrman said. Precisely because medical student experiences and residency training for graduate MDs employ case-study methods extensively at MSU, the new materials, he said, should find broader application, including continuing medical education programs for MDs already in practice.



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Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

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Category I courses

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: July 19-20, Oculo-Plastic Surgery Symposium. Location: Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Ophthalmologists, Otolaryngologists, and Plastic Surgeons. **Cost:** Practicing Physicians — $150, Physician-in-Training — $75. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14½ hours of Category I Credit.

Date: July 24-26, Annual Meeting, Michigan Chapter, American Academy of Pediatrics. Location: Shanty Creek Lodge. **Program by:** Wayne State University Department of Pediatrics. **Contact:** Robert S. Holm, MD, 515 Lakeside Drive, S.E., Grand Rapids 49506, 616/774-9115. **Approved for:** 7 hours of Category I credit.

Date: July 26-27, Coller Penberthy Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center. **For:** Physicians interested in an update on medical advancements. **Cost:** $25. **Contact:** Norma Powers, Munson Medical Center, Sixth and Madison Streets, Traverse City 49684. 616/947-6140. **Approved for:** 9 hours of Category I credit.

Date: July 29, Perinatal Update and 84th Annual Convention. Location: Plaza Hotel, Detroit. **Sponsor:** National Medical Association. **For:** Obstetricians/gynecologists. **Cost:** $50. **Contact:** C.R. Jonas, MD, local co-chairman Detroit Medical Society. 313/831-4075. **Approved for:** 7 hours of Category I Credit.

Date: July 30-31, Speech and the Coming of Age: Prevention, Amelioration, and Treatment of Communication Disorders. Location: University of Michigan. **Sponsor:** Institute of Gerontology, U-M. **For:** Physicians, health specialists, and others who work directly with the elderly. **Cost:** $65. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 East Liberty, Ann Arbor 48109. 313/763-4101. **Approved for:** 10 hours of Category I credit.

Date: Aug. 2-5, Clinical Psychiatry: Doctor-Patient Relationship. Location: Holiday Inn Downtown, Traverse City. **Sponsor:** Michigan Psychiatric Society. **Cost:** $60. **Contact:** Edward S. Salem, MD, 22420 Twyckingham Way, Southfield, 48075.

Date: Aug. 10-12, ECG Interpretation and Arrhythmia Management. Location: Shanty Creek Hilton, Bellaire. **Sponsor:** International Medical Education Corporation. **Cost:** $202. **Contact:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. 800/525-8646 Toll free. **Approved for:** 15 hours of Category I Credit.

Date: Aug. 16-19, 11th Annual Summer Conference of the Michigan Ophthalmological Society. Location: Grand Hotel, Mackinac Island. **Cost:** $75. **Contact:** Susan Grimsley, MSMS headquarters. **Approved for:** 7 hours of Category I credit.

Date: Aug. 24-27, Infectious Diseases and Rheumatology. Location: Grand Hotel, Mackinac Island. **Sponsor:** Towsley Center for CME, University of Michigan. **Cost:** $150. **Contact:** Floyd C. Pennington, PhD, director, Office of CME, University of Michigan Medical School, Towsley Center, Ann Arbor, 48109. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 29, E N T and the Family Physician. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital Dept. of Family Practice. **Cost:** No Charge. **Contact:** Jean Machtel, CME Coordinator, E. W. Sparrow Hospital, 1215 E. Michigan Avenue, Lansing, 48909, Phone: 517/487-2790. **Approved for:** 4 hours of Category I Credit.

(Continued on page 390)

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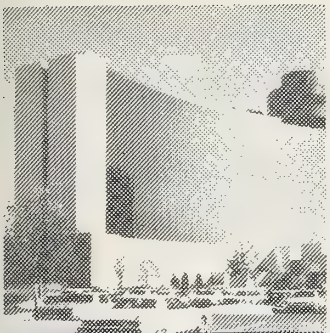

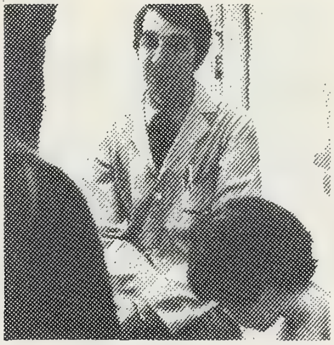
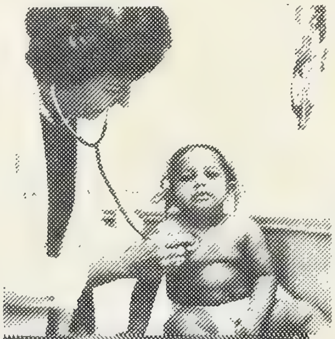

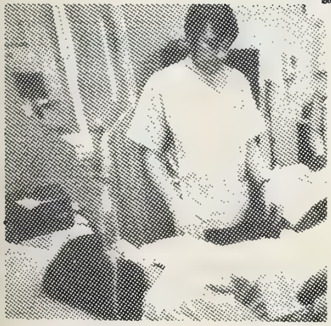

CATEGORY I/*Continued*

Date: Sept. 7-9, Diagnostic Ultrasound. Location: University of Michigan, Ann Arbor. **Sponsor:** Towsley Center for Continuing Medical Education. **Cost:** $160., physicians; $95., physicians-in-training; $95., technologists. **Contact:** Floyd C. Pennington, PhD, Director, Office of Continuing Medical Education, U-M, Ann Arbor 48109. **Approved for:** 16 hours of Category I credit.

Date: Sept. 8, Diagnostic Problems in Neuropathology. Location: St. John Hospital, Detroit. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, or John G. Batsakis, MD, Dept. of Pathology, University of Michigan Medical Center, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: Sept. 10-Nov. 12, Pediatric Seminar IV. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 20 hours of Category I Credit.

Date: Sept. 14-15, Clinical and Radiological Evaluation of Athletic Injuries. Location: Kellogg Center, East Lansing. **Sponsor:** Michigan State University departments of Radiology and Athletic Medicine. **Cost:** $100. **Contact:** Thomas S. Arle, MD, Department of Radiology, MSU, B220 Clinical Sciences Building, East Lansing, 48824. **Approved for:** 10 hours of Category I Credit.

Date: Sept. 17-21, 6th Annual Family Practice Review. Location: Wayne State University School of Medicine, Scott Hall, Detroit. **Sponsor:** Wayne State University School of Medicine. **For:** Family Physicians. **Contact:** Wayne State University School of Medicine, Division of CME, 1206 Scott Hall, Detroit, 313/577-1180. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 19-21, Real Time Ultrasound for the Private Obstetrician/Gynecologist. Location: Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** Department of Obstetrics and Gynecology. **Enrollment:** Limited to 25, pre-registrants only. **Cost:** $500. **Contact:** Towsley Center for Continuing Medical Education, Ann Arbor. 313/764-2287. **Approved for:** 21 hours of Category I credit.

Date: Sept. 26, Diabetes Update. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Sept. 27-30, American Medical Association Regional Meeting. Location: Sawmill Creek Lodge, Huron, Ohio. **Sponsor:** Ohio State Medical Association. **Cost:** $85 per course. **Contact:** Department of Meeting Services, AMA, 535 North Dearborn Street, Chicago, IL 60610, 312/751-6000. **Approved for:** 5 credit hours per course, 1 course per day.

Date: Oct. 5-7, Anesthesia and the Circulation. Location: The Homestead, Glen Arbor. **Sponsor:** Michigan Society of Anesthesiologists and the U-M Anesthesiology Dept. **For:** Anesthesiologists. **Cost:** $75. **Contact:** University of Michigan, Dept. of Anesthesiology, F 3820, Mott Hospital, Ann Arbor, 48109, 313/763-2435. **Approved for:** 9 hours of Category I Credit.

Date: Oct. 18-19-20, Implant Surgery for Joints and Tendons in the Hand. Location: Blodgett Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand, Blodgett Memorial Medical Center. **Cost:** $250. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. 616/774-0440. **Approved for:** 19.5 Category I credits.

Date: Nov. 1, MSU Family Practice Research Day. Location: University Club, Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine. **For:** Family Physicians. **Cost:** $30. **Contact:** Douglas McKeag, MD, Department of Family Practice, MSU College of Human Medicine, B-100 Clinical Center, East Lansing 48824. 517/353-0850. **Approved for:** 8 hours of Category I Credit.

Date: Nov. 5-9, Principles of Milieu Practice: Working With the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** Institute of Gerontology. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 E. Liberty Street, Ann Arbor. 313/763-4101. **Approved for:** 30 hours of Category I credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 28, Updating Core Knowledge in General Surgery. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

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AMA's jail health care standards may become part of Michigan rules, regs

By Jeffrey L. Eubank
Lansing

There is a strong possibility that AMA standards for jail health care will become part of the Michigan administrative code in 1979-80. To our knowledge, this is the first time a state agency has proposed that the AMA jail provisions be mandatory.

The role of the physician is essential in implementing the medical care program. Continued cooperation from physician practitioners will be required for the provisions, should they become mandatory, to be effective.

The AMA developed the standards for medical care in 1977-78, as well as a companion process for voluntary accreditation.

Michigan was one of the original six states in the AMA project which tested the proposed standards. MSMS has carried out the administrative aspects of the state project and has provided technical assistance in helping counties meet the accreditation requirements.

To date 12 percent of Michigan's 77 county jails have already been or are close to being accredited by the AMA. Jails currently certified by AMA are Shiawassee, Oakland, Ingham, Berrien and Muskegon. Washtenaw, Kalamazoo, Lake and Saginaw are in the final phases of the accreditation process.

Mr. Eubank is administrator, Office of Facility Services, Michigan Department of Corrections.

The Michigan experience would indicate the standards will work for both large and small facilities.

Constitutional requirements

The AMA standards establish the framework for the delivery of medical care in jails. They have received national recognition and support. It is our belief that the standards also satisfy Constitutional requirements for proper health care.

The judicial process has and continues to work in its fundamental role of declaring the rights to which citizens, including inmates, are entitled. However, as M. Glenn Abernathy has written, "The judicial process must await the sufficient irritation of the injured parties to energize its machinery . . . "

By statute, the Deparment of Corrections has rulemaking authority. Current rules for jails are being revised, and if adopted will include the AMA standards.

The goal is to establish state rules for the construction and operation of local detention facilities which meet Constitutional standards. The vehicle is administrative, so Michigan doesn't have to wait for Court mandates.

The standards are timely in that medical care for jail inmates frequently is an issue in prisoner litigation. About 1.5 percent of civil courses filed in federal courts relate to prisoner litigation.

Successful lawsuits have contested the prevailing practices and conditions at those facilities. It has been alleged that the sum of conditions constitutes cruel and unusual punishment in violation of the Eighth Amendment of the United State Constitution. In addition it has been argued that most jail inhabitants are in pretrial status. Restricting the rights of pretrial detainees more than convicted inmates in prison violates the presumption of innocence and the equal protection and due process clauses of the Constitution.

At a minimum, courts expect the jail will provide adequate medical care and attention for obvious or suspected conditions and situations.

Physician authority

A key component in the health care system involves the designation of a licensed physician as the responsible medical authority. There is strong emphasis on the development and implementation of written standard operating procedures. Intake screening is required. Provisions for sick call and emergency services also are required.

On adoption, the rules become a part of the *Michigan Administrative Code* and have the effect of law. The rulemaking process requires public hearing and concurrence by a majority of members of the House of Representatives and Senate sitting on the Joint Committee on Administrative Rules.

The rules will probably go to the Joint Committee by mid-summer.

In summary:

— The AMA-MSMS project has helped establish an acceptable medical care delivery system for Michigan jails.

— The role of the physician is essential in implementing the medical care program.

— Continued cooperation from physician practitioners will be required for mandatory provisions to be effective.

Local medical associations and their members should be willing to provide technical assistance in setting up a medical system for the jail and helping recruit physicians to carry out the responsibilities of the designated medical authority.

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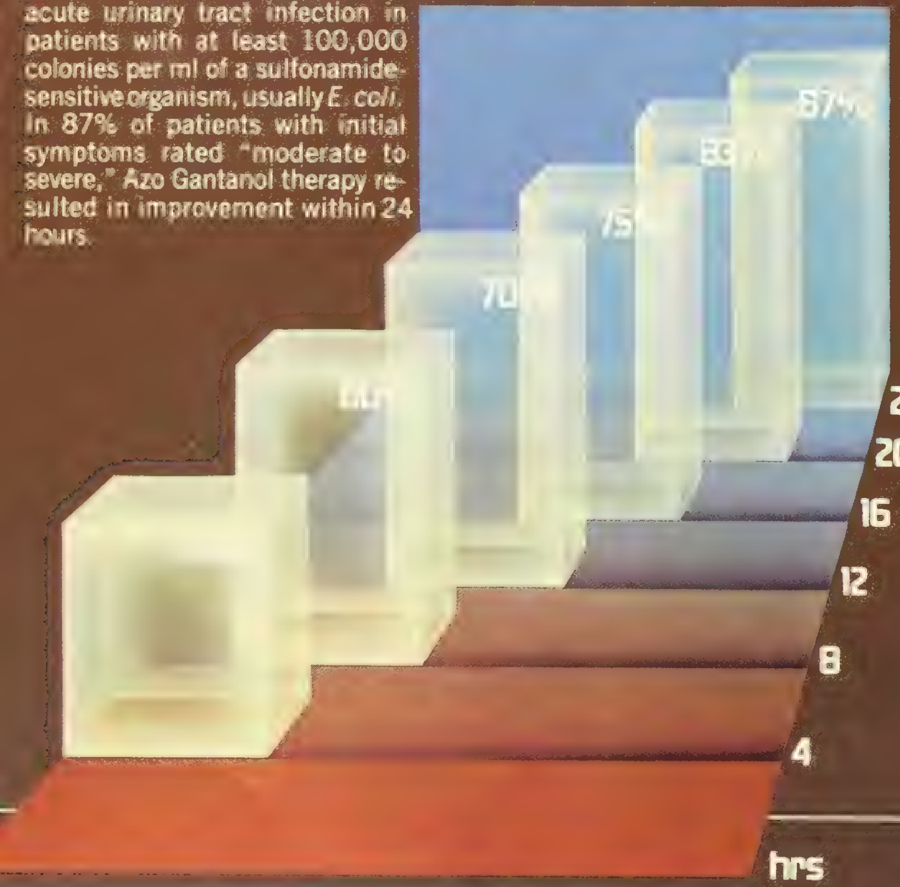
[illegible] data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Fast pain relief plus effective antibacterial action

Azo Gantanol®

[illegible] 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl

for

[illegible] pathogens

[illegible] New Jersey 07110.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Car fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; ad aminobenzoic acid to follow-up culture media. Th increasing frequency of resistant organisms limit the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I disturbances.

Warnings: Safety during pregnancy not establish Deaths from hypersensitivity reactions, agranulo tosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC an urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypopro thrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysi urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis) *G.I. reactions* (nausea, emesis, abdominal pains hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, periphera neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rar instances of goiter production, diuresis and hyp glycemia. Cross-sensitivity with these agents ma exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continue treatment with Gantanol (sulfamethoxazole) ma be considered.

NOTE: Patients should be told that the orange-r dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each contai ing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche I
Nutley, New Jersey 07110

Bill would create Michigan health service corps

By Willah Weddon
***Special to* Michigan Medicine**

Passage of legislation which would establish a Michigan Health Service Corps appears favorable, according to its sponsor, State Representative Bela E. Kennedy.

Under provisions of the bill, a Health Service Corps would operate a loan fund for the education of health care providers who could repay their debt by practicing for two years or more in an area designated as medically underserved.

Kennedy, a Bangor Republican, is convinced this method of providing physicians for rural communities and inner-cities in need of them would be far more satisfactory than the imposition of federal or state regulations.

Extensions of the Federal Public Law 94-484, effective in 1976, declared health providers — physicians, psychologists, social workers and nurses — a natural resource, and fixed the government's responsibility for assuring such personnel are available to meet the health care needs of the American people.

"I would much prefer the voluntary action method rather than mandating by legislation," Rep. Kennedy said. "When you get politicians into these things it's more costly. We aren't the experts in these fields and are bound to make more mistakes."

Proposed Corps structure

Kennedy's proposal (H.B. 4085) would amend the Public Health Code to create the Michigan Health Service Corps within the State Department of Public Health. The Department and the Michigan Office of Health and Medical Affairs (OHMA), would be responsible for its administration.

Rep. Kennedy

Jay G. Endsley, director of OHMA, noted in a memorandum to Governor William G. Milliken that his agency had "participated extensively in the preparation of the bill" and supported its passage.

He also pointed out that students would be able to participate in the program only after it had been determined that a shorage existed in the professional field in which the student was enrolled. "Thus, the program will provide the state with a mechanism to alleviate shortages of health professionals," he said.

State funds must be appropriated by the legislature to put the loan program into effect.

Students in accredited programs could receive funds from the Corps only if they signed contracts binding them to practice after graduation in a health resource shortage area for two years or the number of years for which the loan was accepted, whichever was longer, and agreed to repay the loan within three years after graduating.

It also would allow the contract to require recipients to enroll in the National Health Service Corps.

Underserved areas would be determined by OHMA under guidelines set up by the Statewide Health Coordinating Council (SHCC) and with their approval. (The criteria could not be inconsistent with federal criteria for health manpower shortage areas.) It is anticipated that a "shortage area" would include state correctional and mental health institutions.

Match physicians, areas

Efforts would be made by the Corps to match communities in need of certain kinds of health care providers with the graduates available to serve out their loans. Their goal, according to Kennedy, would be to place the physicians in locations in which they would want to remain after the obligatory stint had been filled.

"This is one of the first bills to tie the National Health Service Corps with a State Health Service Corps," Rep. Kennedy pointed out. He met Howard Hilton, MD, assistant director of the National Health Service Corps under the Department of Health, Education and Welfare, last summer and felt they had a mutual concern. They tried to work out a plan so Michigan could participate in the federal loan program.

If Rep. Kennedy's bill becomes law, even without state funding, it would make it possible to bring in graduates under the federal program and place them in underserved areas in Michigan.

Presently minority vice-chairman of the House Public Health committee, Kennedy has been a member of the committee since first elected in 1971. He had served as a member of the South Haven Hospital Board and was keenly interested in helping rural communities secure medical services.

Politics and medicine two passions of Doctor Berglund, new AMPAC board member

By Charles Downs
Special to Michigan Medicine

When he was a six-year-old in Newberry, Tom Berglund tried to help Wendell Willkie keep Franklin D. Roosevelt out of a third term in the White House.

Perhaps he was influenced by his individualistic grandfather who returned a check the government had sent him for plowing under some fields and letting them lie fallow. It wasn't right, the farmer said, to get paid just for following his normal rotation practice.

Regardless of the reason, politics ever since has been a passion of Doctor Berglund's.

But even before he became aware of politics, he had made up his mind to be a doctor.

The two passions stayed with him through high school in Standish, through the University of Michigan undergraduate and medical programs, through postgraduate training at Bronson Hospital in Kalamazoo and through the past 18 years of family practice in Portage.

Today, Thomas R. Berglund, MD, might make a good candidate for public office.

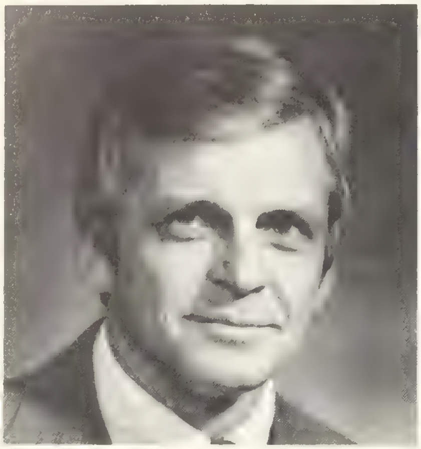
One finds him intelligent, but not a showoff; idealistic, but politically practical; articulate, but not overwhelmingly so; handsome, but not pretty; and young-looking for his 44 years but with a mature cropping of gray in his thick, well-groomed hair.

In spite of such assets, his highest public office has been on a township board and he says he aspires to no state or federal posts.

A major reason is time. "I'm up to my armpits in alligators. I just do not have any more available time.

"Besides, I really enjoy my practice. Politics is my avocation; medicine is my vocation."

AMPAC board member



Doctor Berglund

What keeps Doctor Berglund especially busy right now is his appointment as a member of the AMPAC (American Medical Political Action Committee) Board of Directors.

He is the first Michigan doctor ever named to the 10-member board in its 18 years of existence. His term is for one year but he can be re-elected yearly for a 10-year term. He unabashedly indicates he would like to be there for awhile.

Going to the five board meetings that AMPAC has each year is only a small part of the work ahead. Two of the board meetings are in conjunction with meetings of the AMA House of Delegates, which, as a member he would attend anyway.

What is going to take time will be speaking engagements to county medical societies and other groups, attending special briefings in Chicago and Washington, and committee work — he was assigned to the Membership and Communication Committees.

Political action committee activities are not new to Doctor Berglund. Since 1966, he has been a member of the MDPAC (Michigan Doctors Political Action Committee) board of directors, and for four years until his AMPAC board appointment, he chaired the state board.

But working with AMPAC will be different in some respects from MDPAC. Doctor Berglund gives three reasons why.

"First, AMPAC is a more sophisticated organization. It is extremely impressive and has a staff of six full-time people plus secretaries.

"Second, all the members of the AMPAC board have been actively involved in politics in their respective states. It is a really aggressive group of highly intelligent, motivated people.

"Third, we are talking about a larger organization in terms of money for political support. We are dealing with federal house and senate races rather than the state house and senate races.

"This will be an educational process for me."

Jill, colleagues support

"Our first priority," Dr. Berglund explains, "is to support friendly incumbents."

Doctor Berglund appreciates the support he receives from his brother and other colleagues in a five-doctor practice.

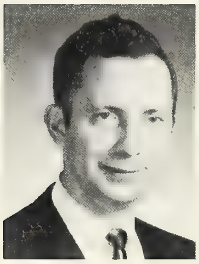
"They take the philosophy that I am helping fulfill their political commitments and have been tremendous about changing calls and arranging weekends to accommodate my schedule. They have even voted me up to two weeks extra vacation for my involvement if I need to use it."

But perhaps the greatest support comes from his wife, Jill. She encourages him, goes to meetings with him and is even serving as the state Auxiliary representative on the MDPAC board. What's more, she is a sustaining member too.

That is all great with Doctor Berglund who believes: "It is everybody's duty to become involved in the political process, to elect those candidates who agree with your philosophy and to try to do what you can to make the laws what you want them to be.

"I like a sign that AMPAC puts out. It says, 'Anyone who says he is above politics is really saying that democracy is beneath him.' "

Medical Treatment Decision Act must be considered for its impact



Doctor Kincaid

by Joseph E. Kincaid, MD
Kalamazoo

On May 16, 1979 the Medical Treatment Decision Act failed to be voted out of the House Public Health Committee. Before this Act or similar legislation is introduced in future legislative sessions, all Michigan State Medical Society members should consider whether this type of legislation will hinder more than help our practice of medicine.

The Medical Treatment Decision Act (HB 4058) permits an individual to designate an agent to act in his behalf for medical care decision-making if that individual becomes incompetent.

This act, presently supported by the MSMS Committee on State Legislation and Regulation, could be a "sleeper" and markedly affect our medical practices.

We should scrutinize most carefully the following provisions of the Act:

1. The agent, without provisions for any medical background, can control all medical decisions involving all modalities, ordinary as well as heroic.
2. The agent's medical decisions take precedence over any desires or instructions of patient, family, physician or legal guardian.
3. Inappropriate actions of the agent can be corrected only through circuit court action.
4. A physician, acting contrary to the agent's wishes, is legally liable.
5. Before a physician withdraws from a difficult agent relationship, he must notify the patient, agent, and other appropriate health care personnel and find a physician replacement.

Doctor Kincaid is an internist.

Law unnecessary

The greatest weakness of the Medical Treatment Decision Act is that it is unnecessary. The Act states "an adult patient has the right to accept or refuse medical treatment in accordance with that person's wishes or desires." However, through Anglo-American common law, the patient already has the right to refuse, personally or through family or legal guardian, the use of life-prolonging devices, and it is unnecessary to enact this into statutory law.

The patient should realize that he, and not the physician, is the master of his fate. The patient should not fear, that against his will, his life will be prolonged by life support machines. He is always free to discuss his preferences for heroic measures with his physician and family and to have these preferences written in his medical chart or carried in his wallet.

Far better it would be to keep medical care decision-making within the intimate and traditional patient-family-physician relationship.

If a public policy or a law is needed to cover critical care decision-making, it would appear much wiser to officially legalize the present situation rather than depending upon bills like the Medical Treatment Decision Act.

Necessary provisions

This public policy or law should include the follwing provisions:

1. Every person has the legal right to refuse medical treatment.
2. Critical care decision-making should remain in the hands of the person with advice and support from family and physician.
3. In case of incompetency of the person, the family has the responsibility of decision-making.
4. In the rare cases of the incompetent person without family or legal guardian, the physician is charged with the responsibility of providing reasonable and appropriate care. The physician should seek consultation with peers such as hospital ethics committees and not feel obliged to make the decisions on his own.
5. A physician, with patient-family permission, who withholds or discontinues medical modalities that do not offer a reasonable chance of benefit will not be violating any medical, ethical or legal sanctions.

Detroit's Tel-Med service one of most popular

By Shelton Reece
Special to **Michigan Medicine**

A small switchboard in the Wayne County Medical Society building received 649,302 different telephone calls in the past 28 months. The calls were made by people seeking information on health related subjects, who dialed 393-1976, the Tel-Med number in Detroit.

Tel-Med, originated by the San Bernardino, CA, County Medical Society in 1972, is an educational medical information service, which costs the caller nothing. To obtain the service, a person dials the number, requests a tape by number or subject listed in the Tel-Med brochure and listens to a tape-recorded three-to-seven minute message.

250 subjects covered

Co-sponsored in Detroit by the WCMS and Blue Cross-Blue Shield of Michigan, Tel-Med tapes cover about 250 subjects. Tel-Med's brochure lists the subjects individually in the following general categories: first aid, children, parents, women, men, pregnancy, birth control, venereal disease, drug abuse, care of teeth, care of the patient in the home, public information, safety, heart, cancer, respiratory, skin disorders, digestive system, arthritis-rheumatism, alcohol problems, smoking, vision and hearing, mental health, nutrition, and veterinary.

The concise messages are intended specifically to help callers — who need general information — to remain healthy, recognize early signs of illness, and adjust to serious illness. They are not designed to be used in emergencies, to self-diagnose illnesses, nor to replace physicians.

The Detroit system was initiated by a task force headed by WCMS past president, James Danforth, MD. It began operation in October, 1976 and was the first of its kind in Michigan. The system utilizes a Teletronix unit which can handle 15 different calls at one time. It is activated when a caller tells the operator what tape is desired.

Though most of the messages are written by San Bernardino County Medical Society members and all are recorded by professional narrators, physicians from the WCMS public health and public relations committees, and from Blue Cross-Blue Shield, carefully review all tape scripts, prior to recording, and make any additions or deletions they feel necessary before final taping. Detroit area physicians wrote the script for tape number 130, "Drug Abuse Resources in Wayne, Oakland and Macomb Counties."

Brochures, which list every tape by name and number in the Detroit system and detail information about Tel-Med, are distributed through schools, doctors' offices, health agencies, and Blue Cross-Blue Shield's Public and Community Relations Departments.

"The service has proven so popular that we have not made a concerted effort to publicize it by other methods," according to Roger Mecum, the society's executive director.

Mecum reports that, by caller volume, Detroit's Tel-Med is one of the most popular in the United States. Not surprisingly, the operators' busiest times of the year are during fall and winter months.

Females use more

"Our records show that females use Tel-Med here about three times more often than males and that adults make approximately three-fourths of all calls. The most frequently requested tapes are those on sexual subjects, followed closely by messages concerning cancer, smoking, birth control, and those regarding children."

There are more than 175 Tel-Med systems operating in cities throughout the United States. All are licensed by the San Bernardino Medical Society, and each pays an annual fee for usage to that society. In Detroit, Blue Cross-Blue Shield underwrote the initial start-up expense and contributes to maintenance costs.

MOVING?

Michigan Medicine wants to know

Please notify us a week or two in advance.

CHANGE MY MAILING ADDRESS TO:

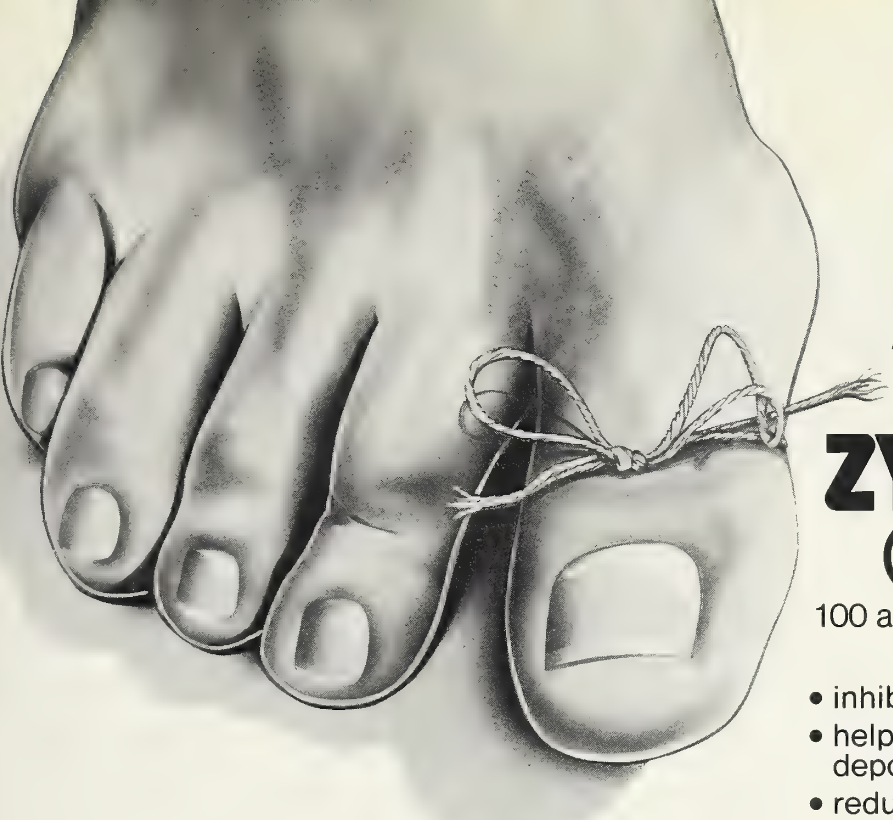
Name

Address

City **State** **Zip**

Please paste old mailing label here:

Please send to: Peg Berry, MSMS, P.O. Box 950, East Lansing, MI 48823.



A reminder

ZYLOPRIM®

(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Kellogg Foundation administrator: availability of care #1 problem

(Editor's Note: The following interview with Andrew Pattullo, senior vice president of the W. K. Kellogg Foundation, was developed by Herbert A. Auer, executive vice president of the Michigan Health Council. Mr. Pattullo came from the hospital field in 1943 to further the Kellogg Foundation concerns with hospitals. Mr. Pattullo is a member of the "Health Hall of Fame" of the Michigan Health Council. The Michigan Health Council, which has received many grants from the Kellogg Foundation, is a voluntary, non-profit, non-governmental organization with 152 member organizations from the closely related fields of health, education and industry, including MSMS.)

QUESTION: What health problems does Kellogg see in Michigan?

ANSWER: "While Kellogg is now supporting some 350 projects in the health field in four continents — it must be pointed out that the problems are universal, the differences being only in the degree.

"The five common health problems, as seen by our staff are: (1) the public's ability to obtain health services; (2) the cost and productivity of health care; (3) the continuity and comprehensiveness; (4) or the degree of quality care, and, (5) the omnibus dimension of health promotion and disease prevention."

QUESTION: How does Kellogg help to resolve these problems?

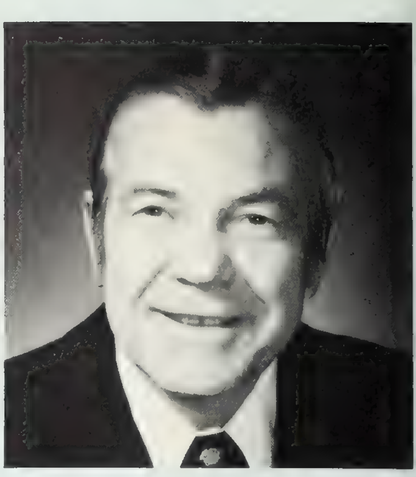
ANSWER: "To deal with these five health care problems, there is a need for more primary care, family physicians and for possible changes in the mode of practice.

"The Kellogg Foundation has and is working to encourage more family medicine residency training programs in Michigan and the nation, and also to help prepare faculty for such new family practice departments.

"Solutions also are sought to problems that are created because many young physicians are reluctant to practice in a solo situation and in relative isolation from other physicians. Yet, this is often the reality of establishing a medical practice in a smaller or rural community.

"Insofar as affecting the mode of physician practice in smaller communities, we have recognized a need for different approaches to the problem. Ways and means must be tested to develop viable patterns that will be (1) attractive to the young doctor and (2) transferable as models."

For example, the Foundation has supported projects in both south central Michigan and the Upper Peninsula aimed at improving the availability and distribution of primary care specialists and family practitioners. Many focus on creation of family health centers and regional family practice residency programs. Surveys have shown that 60 to 70 percent of physicians enter medical practice in the area where they complete their residency education. So, this is one approach to the problem of access and availability of health care in the rural areas.



Mr. Pattullo

QUESTION: How many health grants are currently in effect for Michigan projects?

ANSWER: "The Kellogg Foundation today is assisting 29 Michigan projects in health — all related to resolving one or more of the five health care concerns mentioned earlier. The Foundation has committed $13,341,383 to these projects. Each project, no matter how modest or small, is deeply concerned with a very, very real problem that faces the people of Michigan — the need for a health system that is equitable in access, assured in quality, comprehensive in scope, and provided at a reasonable cost with a deep concern for humanity and compassion."

QUESTION: How did the project work out when Kellogg was helping new two-year medical schools?

ANSWER: "Over a 15-year period the Kellogg Foundation provided financial support to eight so-called 'schools of the basic sciences' or two-year medical schools. Michigan State University was one of the schools which benefited.

"All these two-year schools were in areas where there was a definite

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Mr. Pattullo is senior vice president with responsibility for the daily administration of the Kellogg Foundation, and is a member of the Foundation's Board of Trustees. He is an honorary fellow of the American College of Hospital Administrators, has served actively in both state and national associations concerned with health care and the education of health personnel, and has received numerous honors for his contributions to the health care field. He was a member of the Federal Hospital Council and since 1962 has served as consultant to federal health programs.

need for physicians within the region and where there also was a university with the necessary capabilities.

"Each of the eight Kellogg Foundation-assisted two-year medical schools is now a full four-year institution. These schools are producing many needed physicians across our nation."

QUESTION: How did Kellogg happen to finance Intensive Care Units for smaller Michigan hospitals?

ANSWER: "This 'success story' resulted from our support to some 30 small community hospitals (like Frankfort, Crystal Falls) in developing ICU's, and which have helped to reduce mortality from certain health problems. All of this happened because Malcolm Dolbee, MD, of Standish, participated in a postgraduate course at the University of Michigan Medical Center on the use of intensive care units for coronary patients. Doctor Dolbee asked us, 'If the ICU has merit at U-M why not in the smaller community hospital?' The Kellogg Foundation provided the financial push to try the idea — and it has been most successful."

QUESTION: How much has Kellogg granted in Michigan?

ANSWER: "Since 1930, the Kellogg Foundation has contributed some $75 million in Michigan with well over half in support of health programming. These have included a wide spectrum of activities and projects ranging from support of programs in Michigan academic health centers to small community hospitals, health departments and community health programs."

The Kellogg Foundation was established in 1930 by W. K. Kellogg, the breakfast cereal pioneer in Michigan, "to help people to help themselves." Mr. Kellogg continued his personal interest in the Foundation until his death in 1951 at the age of 91.

QUESTION: How extensive are the Kellogg grants, and in what general fields? What's the impact?

ANSWER: "The Kellogg Foundation has grown from its initial gift of $50 million from Mr. Kellogg in the early 1930's to assets today of some three-quarters of a billion dollars. The first efforts were limited to seven southwestern Michigan counties in the 'Michigan Community Health Projects.' Now, Kellogg supports projects in four continents. The three major areas of concern are health, agriculture and education.

"Foundation resources may seem large but in fact are very small in terms of social problems, needs, and total dollars spent.

"For example in the health field, total current expenditures in the United States are $160 billion yearly, and that figure is almost certain to escalate in the future.

"In this context, one foundation can do but little. One foundation can only be regarded as a relatively insignificant resource, but with the hope that its grants can help 'to make a difference'."

QUESTION: What do you mean by "making a difference" and what philosophy does Kellogg practice when evaluating grant requests?

ANSWER: "The Kellogg Foundation, and others, often provide risk capital for ideas that otherwise might be difficult to carry out.

"It is an obligation of foundations to provide venture capital and not help only the sure thing.

"Foundations must plan carefully where their dollars can be expended so the grants can make a difference in helping to resolve or grapple with a particular need.

"The Foundation programming philosophy is to apply knowledge to the problems of people — not problems of institutions or professions. Kellogg looks at requests from the patient's view and not necessarily from that of the physician, dentist, nurse or hospital."

QUESTION: What are your personal views about the Michigan Health Council and its potential to help resolve health problems in Michigan?

ANSWER: "As a past president of the Michigan Health Council and former long-time Board member, I know personally about the excellent work by MHC in Michigan to acquaint young people about possible health careers, about the effective work to bring many physicians and dentists to Michigan and about the health education programs. The Health Council currently is carrying out projects to improve health care in rural Michigan and is conducting a massive health manpower survey — with Kellogg Foundation grants to implement both needed projects. I have no doubt that the Health Council itself will continue its commitment to the same broad goals of the Kellogg Foundation."

Hospital staffs have new strength in Wayne County Medical Society

By Roger F. Mecum
Detroit

The members of the Wayne County Medical Society have adopted bylaws amendments which will totally change the representative structure of the county society.

Michigan physicians are watching developments since the passage of the bylaws amendments by the Wayne physicians, who have the largest county medical society in the state.

The amendments change the method of selecting representatives to the WCMS Council, as well as the delegates and alternates to the Michigan State Medical Society.

The changes are to give broader representation to hospitals throughout the county, and to stimulate greater participation of the membership in society activities.

The new bylaws culminate a considerable effort over a period of years by the WCMS Planning and Priorities Committee, chaired by Frank B. Walker, MD; the Bylaws Committee, chaired by Robert B. Allaben, MD.

First changes in 40 years

The membership's approval came in April and resulted in the first changes in WCMS election procedures and member representation in 40 years.

Current 1979 officers and delegates will continue to serve until the new plan becomes effective in June of 1980. Instead of winter elections, the new bylaws require a mail ballot in April, and the WCMS annual meeting to be held in June. C. Jackson France, MD, will serve as president until June, 1980 when Kenneth J. Ray, MD, will become the first WCMS president under the new representative system.

For the first time, the WCMS will have elected representatives from the county hospitals, as well as elected representatives from four geographic districts. Also for the first time, the delegate body will be developing action resolutions for implementation by the county society, as well as resolutions for MSMS.

The new delegate body to both WCMS and MSMS will be composed of the president (who shall be the chairman), president-elect (who shall be vice-chairman), secretary and one voting member for each hospital designation and geographic district based on a ratio of one delegate for each 25 WCMS members.

This new plan is in contrast to the present system of MSMS delegates nominated by a committee and elected by the membership-at-large. However, the president-elect, secretary and trustees will continue to be elected by the membership-at-large.

All society members listed under a hospital affiliation or geographic affiliation are eligible for nomination to the delegate body, and will be asked to have their names put in nomination. Ballots to each member by hospital and geographic district then will be prepared and mailed.

The delegate body will receive and review all reports and actions of the WCMS council, and will present a report and/or recommendations to the Council following each meeting. The delegate body will meet at least quarterly.

Council elected by delegate body

The WCMS Council now will be elected by and from the delegate body instead of by the membership-at-large, as formerly practiced. The Council will be composed of 15 members by the delegate body, along with the society officers, members of the board of trustees, and the five MSMS councilors from Wayne County. The following members are ex officio without vote: treasurer, editor of the Detroit Medical News, chairmen of the Ethics, Public Relations, Public Health, Government Programs, and Membership committees.

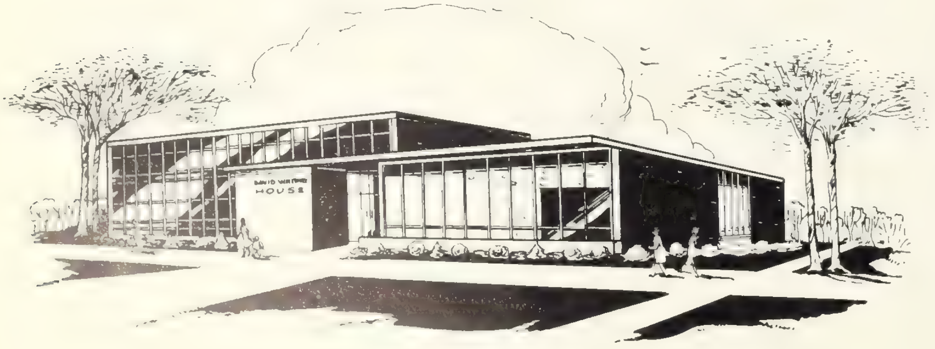
The Council will meet monthly, instead of on the current bi-monthly schedule, and will continue as the governing body of the WCMS.

The "purposes" of the WCMS also changed with the adoption of the new bylaws amendments. They were expanded and rewritten to more accurately describe the current activities and programs of the society.

With these coming changes at WCMS it is hoped communications with the membership will be opened, and that this information will flow through the hospital medical staffs.

The Planning Committee of the Society has now been charged to review in detail other areas of the bylaws, particularly the committee structure and membership categories, and develop recommendations for submission to the Council.

Mr. Mecum is executive director of the Wayne County Medical Society.



DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

GENERAL PRACTITIONER — to provide medical care in a small state facility for the mentally retarded, located in a rural setting in Michigan's beautiful Upper Peninsula. Current salary $46,625 plus a liberal Civil Service fringe benefit package. Limited housing available at moderate cost. Write Steven A. Myers, M.D., Chief of Clinical Affairs, Newberry Regional Mental Health Center, Newberry, Michigan 49868.

WANTED: Full-time Deputy Chief of Medical Staff for 350-bed accredited Hospital providing rehabilitation, psychiatric and chronic disease services. Prefer Internist with administrative experience. Successful candidate must have Michigan license. Excellent salary and fringe benefits. Submit qualifications to: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

WANTED: Orthopod, Internist, Physiatrist, Gynecologist; Full or Part Time, for evaluation work. High Income, No Hassles. Phone H. Lewis, MD, at (313) 767-2600.

POSITIONS WITH STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the fall of 1979. Primarily interested in board certified or board eligible internists, orthopedists, and psychiatrists. Office locations at Lansing, Oak Park and Traverse City. Salary in mid 50's with approximately 23% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, M.D., Chief Medical Consultant, (517) 373-7330. In Michigan, call toll free 1-800-292-2710.

PHYSICIAN-DIRECTOR needed for Jackson Medical Center, Inc., a non-profit clinic providing medical care for patients in need, regardless of ability to pay. A permanent position with very attractive salary (approximately $50,000), 40 hour work week, no week-ends, no hospital duty. Excellent recreational area in rolling farm country with city population of 50,000. Prefer internist or family physician. Contact: F. S. Korotney, M.D., 720 W. Franklin St., Jackson, Michigan 49201.

GENERAL PRACTICE OPPORTUNITY. Replacement desired. Small town, South Central Michigan. 1000 population with surrounding service area over 15,000. Excellent schools. Excellent community hospital facilities at Albion, 9 miles, and Jackson, 15 miles. Opportunity for obstetrics. I am planning to discontinue practice December 31, 1979. Contact A.H. Keefer, MD, 209 Homer St., Concord.

EXPERIENCED GENERAL SURGEON needed to join two general internists, a gastroenterologist, four family practitioners and a pediatrician in a busy Satellite of the Marshfield Clinic at Ladysmith, Wisconsin. Complete details and personal interview will be arranged for qualified applicants. Send curriculum vitae, bibliography and three references to William M. Toyama, M.D., Department of Surgery, Marshfield Clinic, 1000 N. Oak Avenue, Marshfield, Wisconsin 54449.

BUTTERWORTH HOSPITAL, a 554-Bed Acute Care Facility, is seeking a Medical Director for its Ambulatory Care Center. The Center, currently under construction will be completed in September of this year. Qualified candidates should be board certified or eligible physicians in Internal Medicine or Family Practice with Ambulatory Care experience. 3-5 years of clinic and administrative experience is preferred. The position will report to the Executive Director of the Hospital and be responsible for administrative and clinical management of the Center. Salary and starting date are negotiable. Interested candidate should send curriculum vitae to: Donald E. Walchenbach, Executive Director, Butterworth Hospital, 100 Michigan St., N.E., Grand Rapids, MI 49503.

PEDIATRICS, Educational Program Director. Applications are being accepted for this full time staff position with the Southwestern Michigan Area Health Education Center. This is a challenging opportunity in a clinically stimulating environment with an academic atmosphere. To be considered, an individual must be a fully trained pediatrician and certified (or imminently so) by the American Board of Pediatrics. Duties and responsibilities will encompass many areas of activity including undergraduate, graduate and continuing medical education. A complete job description is available on request. Compensation will include a generous stipend and fringe benefits package as well as a regular appointment to the faculty of the College of Human Medicine of Michigan State University. For details Contact: Robert M. Nicholson, MD, Executive Director, Southwestern Michigan Area, Health Education Center, 252 East Lovell Street, Kalamazoo, Michigan 49007. 616/383-7896.

THE MARQUETTE AREA physicians are seeking board certified or eligible Pediatrician with special interest and ability in neonatology for this growing community in Michigan's Upper Peninsula Designated Regional Special Care Nursery providing level 2-3 care. Opportunity to combine neonatology with general pediatric care in conjunction with area's other Pediatricians. Immediate opening created by established physician's return to university setting. Teaching opportunities with medical students and family practice residents. Send inquiries and curriculum to: John Wojcik, MD, Chairman, Recruitment Committee, Marquette General Hospital, 420 West Magnetic Street, Marquette, Michigan 49855. (906) 228-9440.

Miscellaneous

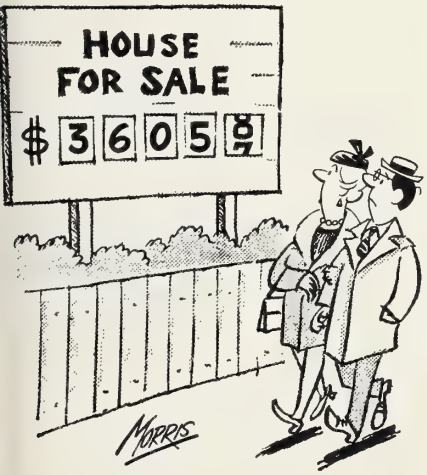
LUXURY SKI CHALET at northern Michigan year-around resort. Completely, beautifully furnished and equipped. Five large bedrooms, three full baths. Golf, tennis. Excellent airport 10 minutes. Near Torch and Chain-o'-Lakes. Rental management and timesharing available. Immediate occupancy. Ideal for joint ownership. Owner, (616) 587-9241.

MEDICAL AND DENTAL OFFICE under construction — Tremendous growth location, 16 Mile just east of Ryan Road, Sterling Heights. Available soon. Call B. Monast at 313/542-7100.

OFFICE SPACE FOR LEASE between 14 and 15 Mile Road on Utica Road, Fraser. Summer of 1979. Next to golf course, airport. Across from hockey, racquet ball and tennis complex. Near St. Joseph West and South Macomb hospitals. 313/772-5070, 313/286-5757.

PROFESSIONAL BUILDING, Orchard Lake near 13 Mile, Farmington Hills. Medical Suite — Planned for efficiency, 3 treatment rooms, private office or separate waiting room, lab, receptionist station, plus hallway work station. Adjoining lab and x-ray facilities could be shared. Ideal for limited Specialty Practice. Available July 1, 1979. Call Mrs. Grunewald, (313) 625-7546.

PHYSICIANS OFFICE SPACE FOR LEASE located in Country Meadows Village Center, in the center of a rapidly expanding suburban population, 5 miles north of Lansing. 800 to 1300 sq. ft suites available. Separate heating and air conditioning, carpeting, vinyl wall covering, completely landscaped, ample well lighted black topped parking. Will remodel to suit. Country Meadows has many single family homes and duplexes, proposed apartments, golf courses, Athletic club and 53,000 square ft. of retail space with I.G.A. Foodliner and Muir Drugs open for business. Four (4) more stores to be open by July. For leasing information contact Anthony V. Scruby or Ronald J. Decker, Long Development, Inc. 6910 S. Cedar St., Lansing, Michigan, 517/694-8147.



Disciplinary Actions, Michigan Board of Medicine

Meetings of Feb. 7, and May 3, 1979.

The following actions of the Michigan Board of Medicine are taken from official memoranda to MSMS and are not editorialized:

KLAUS T. GRAEFER, MD, Leucadia, CA. Letter of Reprimand — ". . . unprofessional and dishonest conduct." Issued April 4, 1979.

RICHARD E. HUGHES, MD, Long Beach, CA. Voluntarily Surrendered License — shall not apply for reinstatement in the State of Michigan for at least 3 years. Issued May 3, 1979.

ANTHONY MARTINEZ, MD, Ecorse. Revoked — Prescribing drugs for other than legal and therapeutic purposes. Issued March 1, 1979.

LARRY L. KOMPUS, MD, Bloomfield Hills. License Summarily Suspended — ". . . unprofessional and dishonest conduct." Suspension dissolved by order of the Board on Feb. 22, 1979. Doctor Kompus' license is thereby current and valid.

JEROME J. WISNESKI, MD, Grand Rapids. License summarily suspended — ". . . selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes." Issued May 3, 1979.

MARCO FARIMA, MD, Southfield. Denied extension of temporary license. Issued March 1, 1979.

PEDRO BERDAYES, MD, Detroit. Converted Limited License to Unlimited License with restrictions. A. Will not apply for Michigan Controlled Substance Registration without obtaining prior Board approval. B. Will not ingest, inject or administer addicting substances. C. Shall not prescribe or dispense or possess controlled substances. Issued April 12, 1979.

MAURICE C. LOREE, MD, East Lansing. Denied license due to non-conformance with the Continuing Medical Education Statute.

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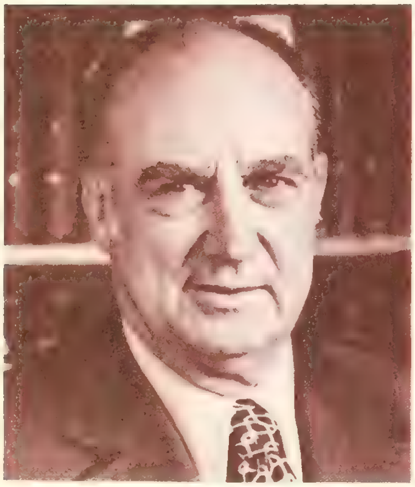
Import Motors	375
Lease Car of America	386
Eli Lilly	387
Mead Johnson Pharmaceutical Division	381, 382, 383, 384
Medical Protective Co.	379
Mercywood Hospital	388
Merck, Sharp and Dohme	366
Merrell-National	370, 371
Michigan Physicians Mutual Liability Company	367
MSMS Annual Scientific Meeting	389
Roche Labs	363, 394, IBC, BC
Sandoz Pharmaceutical	365
Smith, Kline, French	393
Stratton-Cheeseman	391
Upjohn Company	372
U.S. Air Force	390

Society's injudicious use of system contributes to high health care costs

A statewide Michigan program for medical cost containment which achieved favorable results could gain nationwide acceptance and result in significant savings as well as an increase in the quality of medical care.

I will not detail such a program in areas other than medicine, but I do intend to suggest the base on which results could be obtained.



Ernest P. Griffin, Jr., MD
MSMS President

I first described this proposed program at the 1979 MSMS House of Delegates meeting.

The groups involved are the consumer, the employer, the union, the third party payor, the hospital, and the physician.

For the purposes of discussion, the consumer, the employer and the union can be grouped together as our public. Here, our problem is one of education and to some extent the application of the law.

We must enlighten society that its injudicious use of the system is one of the most potent factors in high costs. The insertion of the third party payor does not insulate the public from the cost. This must be delineated.

Correction needed

There are innumerable subsegments that require correction.

Example: The consumer must be made to realize that using an emergency installation such as an emergency room in a hospital, for a non-emergency situation requires the expenditure of a large number of unnecessary dollars.

Example: The drivers of automobiles with recurrent accident rates must be removed from the system. Automobile accidents account for 58% of the deaths in the under 35-years old population. As a physician that sees many accident cases in a large general hospital, I am appalled at the number of times the driver is a recurrent offender. Just think for a moment how many other individuals he brings into the hospital with each one of his accidents.

Example: Concerning the use of lap and shoulder belts, Professor Huelke of the University of Michigan's Highway Safety Research Institute stated that two-thirds of the accident victims with multiple internal injuries would have been hurt less seriously if they had used seat belts.

Other examples: In a recent study, people classified as problem drinkers reported approximately three times the number of accidents as the control group. The recurrent drunk finally ends up in an alcohol-related terminal disease.

Others are the diabetic who either does not understand his disease or does not care, the obese persons who have developed a host of diseases as a result of gorging themselves and are leading their offspring in the same direction, and the smoker.

Self-abuse limited

Consequently, I believe the individual's right of self-abuse must be limited when others pay for the consequences of that abuse. The possibilities are unlimited and we can furnish the medical proof and strongly encourage society to use it.

The third party payors. The records of these organizations must be made available to a responsible group for study in order to determine that every dollar is properly utilized. The administrative cost could be systematically analyzed and made cost effective and it would follow that the activities of hospitals and physicians would also come under scrutiny.

Hospitals. Presently, there is no accurate cost-accounting and comparison between hospitals. What the actual cost-per-day per patient should be has never been determined. It should be possible to arrive at a sum that indicates the best value per dollar expended.

Next time: How physicians can effect cost containment.

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
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- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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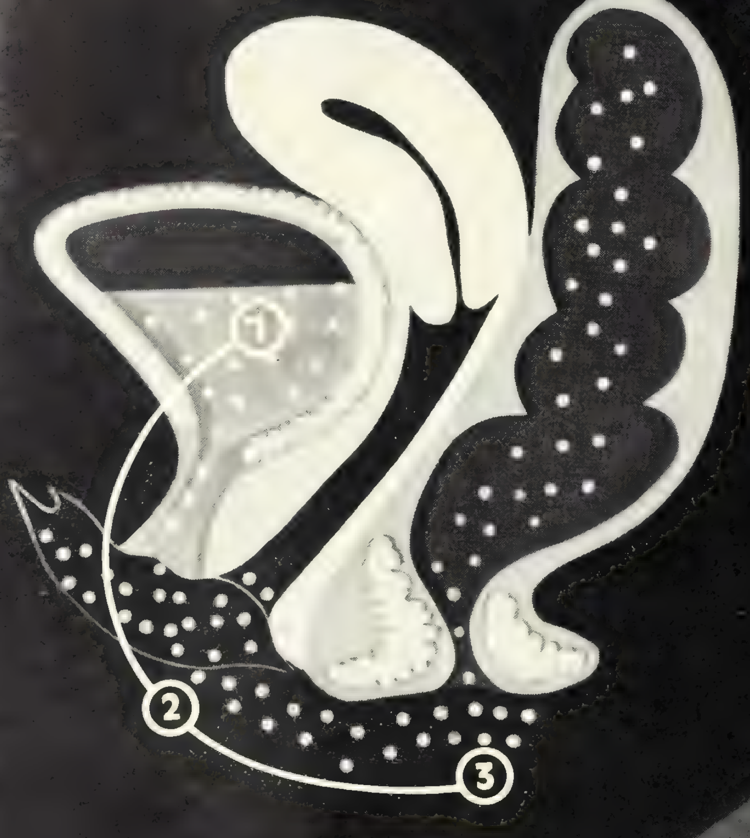

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of res tant organisms. Thus, Bactrim reduces the risk of intro colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 21 JULY 30, 1979

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CAPSULES

MSMS LEGAL COUNSEL is awaiting further action of the Federal Trade Commission on its proposed complaint against MSMS. Nothing has been heard from the FTC since MSMS lawyers made their final attempts to modify the language of a proposed consent order a month ago. If the FTC ultimately is successful in its proceedings against MSMS, its action probably would have a significant impact on physician ability to have meaningful input into the development of third party payors, including Blue Cross/Blue Shield of Michigan.

* * *

A NEW VICE PRESIDENT and medical director of Blue Cross/Blue Shield of Michigan has been named to succeed retiring Louis F. Hayes, MD. He is Armen Shekerjian, MD, former medical consultant with the Michigan Department of Public Health. Doctor Shekerjian has been a general surgeon in the Detroit area over 20 years, and was assistant medical director for Detroit Edison. Doctor Hayes has held the BCBSM post for 11 years.

* * *

A RECEPTION FOLLOWING the Sept. 12 MSMS Council meeting will honor the new director of the Michigan department of Mental Health, Frank Ochberg, MD. Doctor Ochberg assumes his new position in early August, succeeding acting director Vernon Stehman, MD. Doctor Ochberg formerly was associate director of the National Institutes of Mental Health.

MSMS efforts save parity in Medicaid payments to MDs

MSMS successfully retained language in the Medicaid appropriations bill calling for payment of fees at par with current Medicare screen levels. Just before summer recess, July 15, David Siegel, MD, chairman, MSMS Medicaid Liaison Committee, went into action to thwart last-minute attempts to delete the parity portions of the bill. He re-emphasized to key legislators the importance of continuing efforts to achieve parity to maintain a high level of physician participation in the Medicaid program. The Medicaid appropriations bill has been passed by both legislative houses, but not signed by the governor, who is expected to veto the $1 line item for Medicaid-funded abortions.

The Medicaid Liaison Committee will meet Aug. 9 to select elective procedures for the second opinion surgical program cost-containment provisions of the Medicaid bill. The second opinion measure was favored by MSMS over another proposal for prior authorization of hospital admissions.

Doctors Coury and Potchen elected to AMA posts

Michigan's only physician on the AMA board of trustees, John J. Coury, MD, has been re-elected to a second term on the board at the AMA Annual Meeting July 22-26 in Chicago. News of his election was just received as this issue went to press. Doctor Coury was first elected to the board in 1976 and has risen to appointment as chairman of the AMA Finance Committee. Another Michigan physician, E. James Potchen, MD, has been elected to the AMA Council on Medical Education. Doctor Potchen is chairman of the MSU College of Human Medicine Department of Radiology. Further details of Michigan activity at the AMA Annual Meeting will follow in subsequent Medigrams.

THE CALL IS OUT for abstracts to enable selection of papers for Michigan State University's Family Practice Research Day III Nov. 1. The deadline for the abstracts is Sept. 21. Co-sponsor is the Michigan Academy of Family Physicians. Complete details are available from Douglas McKeag, MD, Department of Family Practice, MSU, East Lansing, 48824.

* * *

MSMS MEMBERS ARE URGED to discard MSMS Maternal Health Desk Reference Card #2 now in their files. This card is outmoded, and has been replaced by the new card #23, which was published in the April issue of Michigan Medicine. Card #23 then should be renumbered #2. Members who need a copy of the new card may contact Katie Brewbaker at MSMS headquarters.

Plan to attend!
Annual Scientific Meeting
Nov. 13-14-15, 1979
Hyatt Regency Dearborn

Council asks Michigan MDs to study health planning guides

The MSMS Council is asking Michigan physicians to review and report back on the new National Guideline for Health Planning issued by HEW. The guidelines will be used by HSAs to rule on Certificate of Need applications and will limit the growth of services they describe. The guidelines cover hospital bed supply, hospital occupancy rates, obstetrical services, neonatal special care units, pediatric inpatient beds, pediatric occupancy rates, open heart surgery, cardiac catheterization, radiation therapy, CT scanners and end-stage renal disease. Copies of the guidelines may be obtained from Dennis Paradis, director, MSMS Physician/HSA Support Center, 120 W. Saginaw, East Lansing, 48823 (517) 337-1351.

Statewide health groups have new executives

Two major Michigan Health organizations have new executive directors. The Michigan Association of Osteopathic Physicians and Surgeons' new chief is D. A. "Tony" Deshaw. Mr. Deshaw assumed the new position early in May, succeeding George Abdilla, who resigned. Mr. Deshaw most recently was manager of employee benefits/group insurance plans with the financial staff of General Motors Corp. The Michig Nurse Association's new director is Nadine Furlong, who assumed her duties July 9. Formerly director of nursing with the Metropolitan Psychiatric Instit she succeeds Joan S. Guy, who stepped down to becom associate executive director.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 22 AUGUST 10, 1979

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FTC sues MSMS

On Aug. 6 MSMS headquarters received official notice by certified mail of a Federal Trade Commission Complaint filed against MSMS July 27 in Washington DC.

This is the culmination of an FTC investigation launched in November, 1978 when the FTC subpoenaed a mass of documents from MSMS as part of a national investigation of alleged physician control of Blue Cross and Blue Shield plans.

The FTC in its complaint (see inside pages) alleges that MSMS conspired with its members or its component societies to restrain trade. The Commission also is alleging that MSMS illegally negotiated with the Blues.

As reported in earlier Medigrams, the impact of the case, if the FTC is successful, could be serious. The FTC appears to have made a decision in this case, that physicians should not be allowed any say whatsoever in the development of efficient, cost containment-oriented health care plans by third party carriers which are designed to insure high quality health care. The same decision is evident in other cases across the country involving the medical profession (i.e., recent AMA advertising case).

MSMS, to the contrary, feels that providers are uniquely qualified to have meaningful input in the health care field. MSMS will defend this case with a view toward insuring, when all is said and done, that the physicians in this state be allowed input in developing high quality health care programs.

Kerr, Russell, and Weber, MSMS legal counsel, is presently reviewing the complaint to make an appropriate response. It is expected the case will be in FTC proceedings and then federal courts for years to come. The medical society plans to vigorously deny all charges and fully defend the case. The FTC through this case is attempting to take MSMS out of the business of discussing cost containment with third party payors such as Blue Cross and Blue Shield. MSMS feels strongly that it has a role in promulgating effective and efficient cost containment modes of health care in Michigan.

Cost containment recommendations go to legislative study group

Jack Shelton, chairman of the Health Care Cost Containment Coalition charged with drafting the cost containment sections of Blue Cross/Blue Shield reform legislation, delivered recommendations for cost containment programming to the legislature Aug. 7. Although the document was written without MSMS or any other provider group representation, it was described as "encouraging the private sector to initiate cost containment" with a philosophy that it is desirable that the insurance commissioner should not intervene in cost containment programming unless it becomes necessary.

The document provides for a procedure wherein BC/BSM will develop "reimbursement arrangements that will assure a rate of increase in the total cost per subscriber for a provider class that is not higher than the inflation rate plus real economic growth." This will be subject to insurance commissioner concurrence.

The fact that the Shelton Coalition has not met, formally or informally, with either MSMS or the Michigan Hospital Association was clearly made known to the legislative subcommittee. Mr. Shelton announced to the subcommittee that his group now is prepared to discuss the document with provider groups, and that they will be called to discussions soon.

Full text of FTC Complaint printed inside.

Here is full text of FTC Complaint against MSM

Pursuant to the provisions of the Federal Trade Commission Act, as amended (Title 15, U.S.C. §41 *et seq.*), and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that the named respondent has violated the provisions of Section 5 of the Federal Trade Commission Act and that a proceeding by it in respect thereof would be in the public interest, hereby issues this Complaint, stating its charges as follows:

PARAGRAPH ONE: Respondent Michigan State Medical Society is a corporation formed pursuant to the laws of the State of Michigan, with its principal business offices at 120 W. Saginaw Street, East Lansing, Michigan. Respondent is a professional association for Michigan physicians. Approximately 8,700 physicians are members of respondent, constituting a substantial majority of Michigan physicians.

PARAGRAPH TWO: Respondent charters component medical societies which are organized at the county level in the State of Michigan. Membership in respondent is prerequisite to membership in a component society.

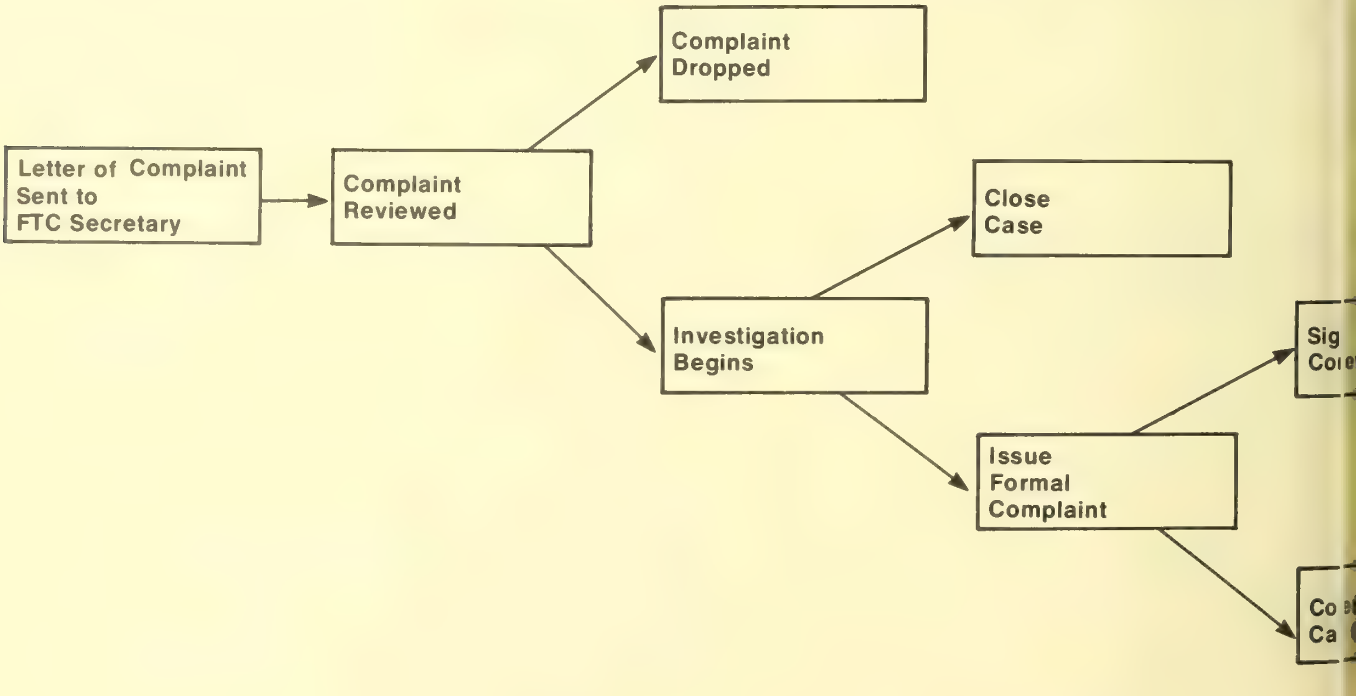
PARAGRAPH THREE: Some members of responden are engaged in the business of providing medical healt care services to patients for a fee. Except to the extent tha competition has been restrained as herein alleged, som members of respondent have been and are now in competition among themselves and with other physicians.

PARAGRAPH FOUR: Respondent is organized for th purposes, among others, of guarding and fostering it members' material interests and insuring that its members receive fair remuneration for services rendered. Respondent engages in activities which further its members pecuniary interests. By virtue of such purposes and activities, respondent is a corporation organized for th profit of its members within the meaning of Section 4 c the Federal Trade Commission Act, as amended, 1 U.S.C. §44.

PARAGRAPH FIVE: Third party payers for health car

Legal procedures open to MSMS

The diagram below describes the legal avenues available to MSMS as options in the FTC Complaint proceedings.



rvices that do business in Michigan, including Blue ross and Blue Shield of Michigan (“BCBSM”) and ichigan Medicaid, and some subscribers of BCBSM, are ngaged in interstate commerce. The acts and practices escribed hereinbelow are in interstate commerce or af- ct the interstate activities of respondent's members, ird party payers or some BCBSM subscribers, and are in affect commerce within the meaning of Section 5(a) (1) the Federal Trade Commission Act, 15 U.S.C §45) (1).

PARAGRAPH SIX: Respondent has restrained competi- on among physicians in the State of Michigan by acting a combination of at least some of its members, or by mbining or conspiring with at least some of its compo- nt societies or with at least some of its members, to:

A. Fix, stabilize, or otherwise tamper with the fees which physicians in Michigan receive for their services.

B. Engage in concerted action to restrict, regulate, impede or interfere with the health care cost containment or reimbursement policies of BCBSM or Michigan Medicaid.

C. Engage in concerted negotiations with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

PARAGRAPH SEVEN: Respondent has engaged in acts nd practices in furtherance of the combination and con- iracy, including among other things:

A. Soliciting and collecting “proxies” from respondent's members which enabled respondent to collectively terminate such members' written agreements with BCBSM and Michigan Medicaid to provide medical services to persons who receive benefits from BSBSM or Michigan Medicaid, if BCBSM and Michigan Medicaid did not adopt reimbursement policies acceptable to respondent;

B. Engaging in concerted action against BCBSM which included, among other things, organizing a concerted refusal by members of respondent to deal with BCBSM.

C. Engaging in negotiations with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

D. Entering into an agreement with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

PARAGRAPH EIGHT: The purpose, tendency and effect of the combination and conspiracy and of the acts and practices described in PARAGRAPHS SIX and SEVEN has been to:

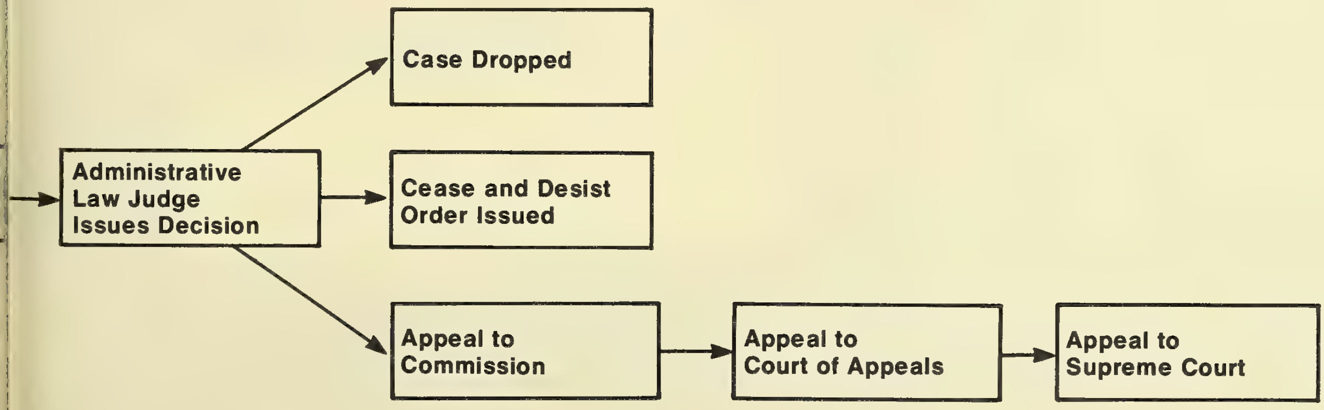
A. Restrain competition among physicians in the State of Michigan.

B. Fix, stabilize, or otherwise tamper with the fees which physicians in Michigan receive for their services.

C. Deprive third party payers of the benefits of competition among physicians in Michigan.

D. Deprive subscribers and consumers of the benefits of third party payers' independently determined reimbursement policies or health care cost containment efforts.

PARAGRAPH NINE: The combination and conspiracy and the acts and practices described in PARAGRAPHS SIX and SEVEN constitute unfair methods of competition and unfair acts and practices in violation of Section 5 of the Federal Trade Commission Act.


Case Dropped
Administrative Law Judge Issues Decision
Cease and Desist Order Issued
Appeal to Commission
Appeal to Court of Appeals
Appeal to Supreme Court

CAPSULES

MSMS IS CONTACTING SHERIFFS around the state to invite participation in the fourth year of the jail health care project. The AMA has awarded MSMS a sub-grant to support technical assistance to 10 jails interested in improving their health care delivery to meet new AMA standards. To date, MSMS has seen nine of 15 county jails involved so far in the program become accredited by the AMA.

* * *

A COMPLETE LIST of Medicaid provider seminars for August, September, October and November was mailed in July to all MSMS members.

The Medical Services Administration of the department of Social Services conducts the seminars in cities across the state to help physicians and their office staffs better understand the Michigan Medicaid invoice processing system, recipient eligibility, program changes and limits, and billing procedures.

Further information is available from the Medicaid Information Division, Medical Services Administration, 300 S. Capitol, P.O. Box 30037, Lansing, 48909.

Physicians may register soon for 1979 MSMS Annual Scientific Me

Physicians should begin to register soon for the 1979 MSMS Annual Scientific Meeting Nov. 13-14-15 at the Hyatt Regency Dearborn. Some courses, particularly the one on Advanced Cardiac Life Support, will have limited enrollments available on a first-come, first-served basis. The ACLS course extends two days and will award 16 credits. There are 57 half-day courses planned at the new, expanded Hyatt Regency Dearborn, with each awarding three Category I CME credits. Registration forms will be printed in the September issue of Michigan Medicine and first September Medigr Physicians must make their own housing reservations early also in order to take advantage of discounts in hotel rates. Further information is available from Sherry Fent, MSMS headquarters.

MSMS Committee on CME Accreditat has increased responsibilities

The MSMS Committee on CME Accreditation now is recognized as the official accrediting agency for intrastate providers of continuing medical education. This new status comes as a result of the July AMA House of Delegates action when the AMA withdrew from the Liaison Committee on Continuing Medical Education and resumed the AMA's previous responsibility for accreditation of institutions and organizations offering continuing medical education programs. The AMA also recognized state medical associations partic ipating in the survey program as the accrediting bodi for intrastate providers of continuing medical education.

Michigan State Medical Society
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East Lansing, Michigan 48823

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CAPSULES

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Contents

August 1979, Vol. 78, Number 23

Michigan Medicine

Special Section

407 **Legislative report: cost containment comes on strong in Michigan bills; Status of key medical legislation;** W. E. Maldonado, MD

Features

412 **Legislative profile: House Public Health Committee Chairman Raymond W. Hood;** Willah Weddon

414 **MSMS members eligible for new rent-a-car discounts**

418 **Two-page spread on MSMS/Intrav photo contest winners**

422 **Meet MSMS President-elect John R. Ylvisaker, MD;** Shelton Reece

435 **Special tear-out brochure details physicians' immunity from peer review liability;** MSMS legal counsel

443 **Joint practice setting pleases MDs, RNs;** Charles Downs

440 **Nearly every major specialty society plans courses at Annual Scientific Meeting**

Departments

417 **MSMS Q/A**

424 **Letters**

427 **Business: Office settings, scheduling and physicians' incomes;** R. Timothy Hogan, CPBC; David Laytner, and Elmer White

433 **Medico-legal: Countersuits, malpractice**

437 **Meetings**

438 **Category I courses**

442 **Views: The physician's public image;** Elmer White

450 **News;** Katie Brewbaker

454 **Welcome: New members**

458 **Deaths**

460 **Classified ads**

461 **Ad Index**

462 **President's Page;** Ernest P. Griffin Jr., MD

W. E. Maldonado, MD, right, chairman of the MSMS Committee on State Legislation and Regulations, meets at the Capitol in Lansing with Rep. Matthew McNeely, chairman, House Insurance Committee. Highlights of the 1979 spring legislative season, just adjourned, and the status of key medical bills are described in this month's special section, beginning on page 407.

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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Health care cost containment legislation makes inroads in public, private medicine

By W. E. Maldonado, MD, Chairman
MSMS Committee on State Legislation and Regulations

Containment of rising health and medical costs took its most severe turn in the spring session of the Michigan Legislature, which adjourned July 15.

Legislation was enacted within the appropriations bill to the Department of Social Services to seek cost containment in Medicaid. (See accompanying article.)

Further legislation was posed to seek cost containment in the private sector through reimbursement rate regulation of Blue Cross/Blue Shield of Michigan.

And even more legislation is promised, when and if BC/BSM cost containment is effective, to extend that program to commercial health insurors such as Aetna and Hartford.

BC/BSM cost control

Most far reaching were various proposals to effect cost controls through Blue Cross/Blue Shield of Michigan, which provides health and medical insurance for more than 60 per cent of Michigan's population.

Begun as an attempt to restructure the board of BC/BSM and make it more sensitive to customer desires, the movement eventually expanded to proposing reimbursement and premium rate control or prior approval, by the insurance commissioner.

Four bills were introduced on the topic. The straight restructuring with language directing BC/BSM to effect some cost containment was introduced originally by Rep. William Ryan and Rep. David Hollister. Then, as the idea of regulation by government took hold, Ryan and Hollister in turn sponsored bills originated by the Michigan Citizens Lobby, the attorney general, and the insurance bureau.

An attempt by all parties to write a "synthesized" bill failed. A task force of three members from the House Insurance Committee, plus Reps. Ryan and Hollister, finally informed Rep. Matthew McNeely, chairman of the Insurance Committee, that it could not reach agreement.

As the session ground toward its recess, Rep. Richard Fitzpatrick, subcommittee chairman, received letters from the governor's office, the speaker's office, the insurance bureau and provider groups, including MSMS, saying action now would be premature in view of the lack of any kind of broad consensus on cost containment and rate regulations.

Speaker Bobby D. Crim and Chairman McNeely then arranged to seek consultation from the "Health Care Cost Containment Coalition" which wrote the original hospital bed reduction legislation of 1978.

Jack Shelton, manager of employee benefits for Ford Motor Co., chairs the task force, with representatives from BC/BSM, the Big Three, UAW and AFL-CIO. It has been asked to submit recommendations for consideration in the fall session, beginning September 18th.

MSMS has developed a program of input to the coalition.

MSMS has not committed itself to the product of the coalition, and will consider the proposals of the coalition as they are generated.

The MSMS principles to be applied to its position on cost containment legislation were hammered out by The Council and the House of Delegates at the annual meeting May 5-6. They are:

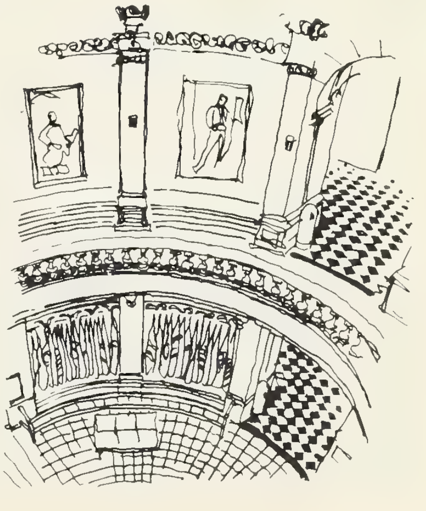
1. That any body considering or developing health care programs, health care facilities, health care financing and health care delivery must have adequate physician input in formulation and adoption of proposals.

2. That all patients and their physicians be treated in a fair and consistent manner in mechanisms for payment of medical services.

3. That physicians as individuals have the right to determine for themselves the method by which they will bill and be paid.

The vital necessity of MSMS influence on the legislation was underscored at a hearing early in the legislative process, when proponents of insurance commissioner rate regulation declared that, once the BC/BSM reform legislation is on the books, they intend to sponsor similar legislation extending the regulatory concept to commercial health insurers.

House action on the coalition proposals should be expected in the fall session. Senate action will follow, but no one can accurately guess at its time table.



Status of key medical bills at close of 1979 spring legislative session

The following list describes the status of key medical legislation at the close of the spring legislative session July 15. The MSMS Department of Government Relations keeps tabs on the many medicine-related bills which are introduced each session. Where it has been formulated, the MSMS position is included in the list.

House bills

HB 4002 Amendments to the Anatomical Gift Act — Removal of Corneas

Sponsor: Rep. Lucille McCollough

This bill establishes a procedure by which a county medical examiner may authorize removal of corneas for transplantation and research purposes, in medical examiner autopsies, without express refusal of next of kin. Amendments to include pituitary glands and middle ears were rejected.

Status: Passed by the Legislature; signed by the Governor. PA 42 of 1979.

MSMS position: Support.

HB 4058 Medical Treatment Decision Act

Sponsor: Rep. David Hollister

This bill would provide for individual rights to accept or refuse medical treatment to prolong life, and allow for appointment of an agent to act in the patient's behalf when patient is unable to act for himself. Physician, hospital liability waived.

Status: House Public Health Committee.

MSMS position: Support.

HB 4078 Legalization of Laetrile

Sponsor: Reps. Kelsey, Trim, Bennett, et al.

This legislation legalizes the manufacture, prescribing or administration of laetrile. The bill relieves the physician of liability or disciplinary action by the Michigan Board of Medicine if the patient's condition continues to deteriorate.

Status: Passed House, referred to Senate Health and Social Services Committee. No action.

MSMS position: Oppose.

HB 4085 Michigan Health Service Corps

Sponsor: Reps. Kennedy, R. Hood, Nash, et al.

This bill has been introduced in an effort to facilitate the retention of health care providers in health resource shortage areas. The proposed legislation establishes a loan program for matriculating students. Upon graduation, a forgiveness of the loan will be granted if the student provides health care in a shortage area for a specified period of time.

Status: Reported by House Public Health Committee, and referred to House Appropriations.

HB 4259 Office of Inspector General — (Social Services fraud)

Sponsors: Reps. T. Stopczynski, S. Stopczynski, Hadden, et al.

This legislation would create an Office of Inspector General within the Department of Social Services to operate independently of the Department. This office would be charged with investigating all incidents of alleged social services fraud by applicants, recipients and employees of service providers, including Medicaid fraud. Case studies would be forwarded to the appropriate prosecuting attorney for disposition.

Status: House Social Services and Youth Committee, several amendments pending.

HB 4349 Requires Cardio-Pulmonary Resuscitation as Part of Physical Education Curricula

Sponsors: Reps. Bullard, M. Brown, J. Young, Jr.

This proposed legislation would require that CPR be part of physical education in schools.

Status: House Committee on Education and House Appropriations Committee.

HB 4436 Second Opinion on Surgical Procedures

Sponsors: Reps. Bennett and Kelsey

This legislation requires patients to supply a surgeon with a written opinion from another surgeon on the necessity of surgery before a major surgical procedure is performed.

Status: House Public Health.

MSMS Position: Opposed.

HB 4586 Extension of Brown-McNeely Fund

Sponsors: Reps. McNeely, Maynard, Sietsema, et al.

This legislation would extend the expiration date of the Brown-McNeely Fund until July 1, 1980.

Status: PA 40 of 1979 (6/22/79).

MSMS Position: Support.

Senate bills

SB 65 Therapeutic Use of Marijuana

Sponsors: Sen. J. Hart, et al.

This legislation attempts to respond to use of marijuana in two areas. It decriminalizes minor use of marijuana and establishes penalties for manufacture and sale of marijuana. The bill also provides for physicians to prescribe marijuana for the treatment of glaucoma, asthma, and to persons undergoing chemotherapy treatments.

Status: Passed Senate — referred to House Public Health Committee and House Judiciary Committee.

SB 157 Medicaid Abortions

Sponsors: Sen. Fredericks, et al.

This legislation would prohibit abortions as a service provided to a recipient of medical assistance (Medicaid), except if the abortion is necessary to save the life of the mother.

Status: Senate Health and Social Services. A motion to discharge the bill from the Committee failed.

MSMS Position: Oppose.

SB 185 Controlled Substances Therapeutic Research Program

Sponsors: Sen. Monsma, et al.

This legislation would establish a Controlled Substance Therapeutic Research Program. This program would conduct research using marijuana to treat patients suffering

Physicians' protection under the peer review immunity act is clearly spelled out by MSMS legal counsel in a handy tear-out brochure on pages 435 and 436 of this issue.

Timetable not yet set for change to triennial relicensing

Triennial registration for Michigan physicians was unanimously approved June 19 by the Joint Administrative Rules Committee of the Michigan Legislature. The rule change was initially proposed by the Department of Licensing and Regulation and received the support of MSMS in the beginning of 1979.

With the passage of the Public Health Code in Section 1222, the Department of Licensing and Regulation is authorized to suggest changes in certain administrative procedures for the sake of administrative efficiency and licensees' convenience. These proposed rules were part of a package proposed by the DLR at the suggestion of Michican State Medical Society to better coordinate re-registration and three year CME reporting for physicians.

The DLR now must formally adopt the rules approved by the Joint Administrative Rules Committee before submitting them to the Governor for review and the Secretary of State for certification. Fifteen days after the Secretary of State certifies the rules they become effective.

It remains undetermined at this time when the triennial re-registration procedure will be implemented by the DLR. Questions as to whether the procedure will be based on alphabetical listings of physicians, license numbers, or percentage of licensees has yet to be decided before implementation will begin. MSMS has been advised by the Michigan Board of Medicine that all physicians will be informed on the new procedure before the implementation begins. MSMS also will advise physicians on the triennial re-registration procedure through its monthly and bi-monthly publications.

1979-80 Medicaid budget finalized

The 1979-80 budget for the Michigan Department of Social Services reflects the Legislature's cost containment mood.

The massive MDSS appropriation includes the funds for the Medicaid program and contains language directing implementation of several programs designed to force reductions in certain Medicaid areas.

In the opinion of the MSMS Medicaid Liaison Committee, some of the proposals have merit and deserve physician cooperation. Others, however, appear no more than paper shuffling that will incur more administrative costs rather than actually save monies.

On the positive side, the Medicaid Liaison Committee supported the proposal for a program of second opinions for selected elective physician and hospital services which is part of the final bill. The committee suggested that a second opinion program would be less disruptive than the original MDSS plan for prior authorization of elective hospital admissions.

The list of selected elective procedures and the protocol for second opinions will be developed jointly by the MSMS Medicaid Liaison Committee and the Department of Social Services in August.

MSMS recommends that the program have a duration of at least three years in order to monitor whether second opinions actually reduce the amount of elective surgery or serve as a postponement mechanism. The program is scheduled to begin by January 1980.

Other cost containment measures of the bill include pre-admission testing before hospital admission, monitoring of recipient utilization of emergency room services, equalization of specialists' and generalists' fees for common procedures and a common billing form for MDSS and BCBSM.

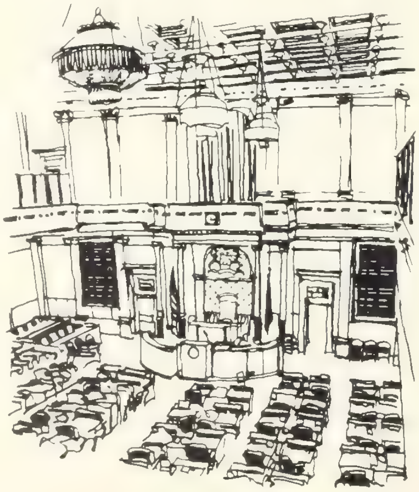
The concept of the common billing form has raised some concern on the part of both MSMS and MDSS. While the form has yet to be developed, cost containment figuring estimates it will be able to account for $10 million in savings to the Medicaid program, beginning immediately with the new fiscal year, Oct. 1.

If the new form is not developed before Oct. 1, or if it results in paper shuffling rather than actual cost reductions, the Medicaid budget will be short the $10 million in anticipated savings.

Although there was a last minute attempt to remove the concept of reimbursements for Medicaid services at current Medicare levels, MSMS was able to preserve the legislative intent that parity with Medicare should be achieved.

David Siegel, MD, as chairman of the MSMS Medicaid Liaison Committee, personally contacted key legislators re-emphasizing the close link between physician participation in Medicaid and fees at reasonable Medicare levels.

Just prior to final passage of the bill, the Medicare parity language was reinserted into the boilerplate of the bill. This marks the third successive year that MSMS has been able to achieve legislative recognition of the importance of Medicaid payments at parity with Medicare.



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with a life or sense threatening situation due to glaucoma or cancer chemotherapy treatments. Patients would have to be physician certified and then approved by a three-member patient qualification review board.

Status: Passed Senate. Referred to House Public Health Committee.

SB 372 Critical Health Problems Education Program

Sponsor: Sen. Faxon, et al.

This legislation proposes mandating local school districts to implement a comprehensive health education curriculum, including communicable and chronic disease education for elementary and secondary schools by July 1, 1981.

Status: Senate Education Committee.

SB 374 Repeal of Drug Control License

Sponsor: Sens. De Grow and Geake

This legislation would repeal Section 17745 of the Public Health Code which requires physicians who routinely dispense drugs from their offices to obtain a Drug Control License.

Status: Senate Health and Social Services Committee.

MSMS Position: Support.

SB 497, 498 Unprofessional Conduct

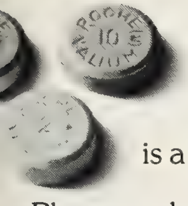
Sponsor: Sen. Corbin

This bill proposes to make it unprofessional conduct for a licensee to promote for personal gain the use of an unnecessary drug, device, service or to require a patient to secure same from a place of business in which the licensee has a "material financial interest." (SB 498 defines material financial interest to mean ownership of more than 5%.)

Status: Committee on Health and Social Services.

Please see profile of House Public Health Committee Chairman Ray Hood (D-Detroit), on page 412.

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® Ⓘⓥ
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

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Chairman of House Public Health committee sees great increase in health bills

By Willah Weddon
***Special to* Michigan Medicine**

"The Public Health Committee is different from other committees. We don't deal in partisanship," State Rep. Raymond W. Hood, committee chairman, said with considerable pride during an interview in his third floor office at the Capitol. "Everyone is concerned about health. The needs of their constituents are considered across the board by Democrats and Republicans."

Hood is in a key position to make these judgments as he has served as chairman of the committee since 1971.

"In those days we had very few bills in our committee," he recalled. "But today people are more health-oriented. We already have approximately 50 bills which have been introduced since the new session got underway in January."

Second opinion bill

One of the most recent referrals, he noted, would require a second opinion be presented to a surgeon by his patient before he could operate. (HB 4436 was introduced by Rep. John Bennett, D-Redford Township, on April 10, and would amend the Public Health Code to read: Before a licensee can perform surgery the patient must present him an opinion from another physician indicating the necessity for it. Penalties include a maximum $1,000 fine or 90 days in jail or both.)

The following article is the eleventh in a series. The articles, written especially for Michigan Medicine *by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.*

Just because a bill has been introduced and sent to his committee does not mean, of course, that Hood supports it. The bill legalizing possession of a certain amount of marijuana is an example. (It was sent to his committee but is being transferred to the Judicial committee.) Hood has strong feelings against the proposal.

"Some say use of marijuana doesn't lead to use of harder drugs and some say it does. I'd rather not take that chance," he stated unequivocally. "Especially as a lawmaker, I'm not about to gamble with the future of our children."

"I just don't think decriminalization is the way to go," he continued. "Our society is getting too permissive now." Hood, raised by stern parents himself, is particularly concerned about the issue because he and his wife, Helen, are raising young sons, Raymond, Jr., 13 and Roger, 11, and planning to adopt a nine-year old niece, Sandra. Their photographs are displayed prominently in his office.

Two other "hot" topics besides the marijuana legislation will be returning for the House's consideration in the fall, he predicted: the "medical treatment decision act," sponsored by Rep. David Hollister (D-Lansing) and the bill to legalize prescription use of Laetrile.

Hood supported Hollister's bill, but "people tied it with euthanasia . . . which it isn't," so it died in committee for lack of support and "we can't take it up again until the first of next year."

Rep. Hood

How some legislators could oppose Hollister's bill and support the Laetrile bill (which passed the House but was held up in a Senate committee) is a puzzle to Hood. "They contend people should have the right to make certain decisions but deny them the right to make others," he said.

Legislator 15 years

Respected by his colleagues as a hard-working, conscientious legislator, the Detroit Democrat was first elected to the House in 1965. He currently serves as the assistant majority floor leader and serves on the Education, Elections, Conservation, Environment and Recreation committees as well as the Public Health committee. It is the latter committee, however, to which he has devoted most of his time and for which he has become known state-wide.

The mild-mannered man with a quiet sense of humor was one of the legislators named to serve on the Michigan Public Health Statute Revision Project. Though the new Public Health Code has been adopted, he expects many changes still will be made.

He is concerned about the reduction of excess hospital beds called for by the new code, and contends it is the small hospitals that will suffer. "If they don't have their quota filled they'll be told to merge with another hospital or be closed down," he pointed out.

"The large hospitals will exist, but community hospitals are vital and important too."

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg

(1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

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Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
Before prescribing, see package insert for full product information.

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The Michigan State Medical Society has entered into an agreement with Avis Rent A Car System, Inc. to provide a significant discount to all members of the society.

Effective August 1, 1979, MSMS members will receive the following discounts from Avis Rent A Car:

- A 30% discount off normal time and mileage charges (customer furnishes gasoline).
- A 10% discount off normal and flat rates in Canada.
- A 20% discount off normal time and mileage rates in Canada and Europe.

To assure receiving the special discounts right at the counter, MSMS members should handwrite the Avis discount number *A/691900* on the back of their membership card. When a member shows his membership card with the Avis AID number written on the back of it along with a credit card accepted by Avis he will automatically receive the discount at the counter.

If MSMS members prefer, they can request an Avis AID card or sticker. By placing the sticker on their credit card or showing the AID card at the counter along with a credit card accepted by Avis, the member will automatically receive the discount at the counter. Members can obtain discount stickers or cards by contacting the Avis Sales Office listed below.

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Avis District Sales Office
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313-357-4000

Tenuate® Ⓒ IV
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

8-3921 (Y587A)

Overweight may not always be simple... complications can develop.*

Complicated or not...

Tenuate® Dospan® ©IV

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

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Now there are three Motrin tablet strengths to choose from–
600 mg, 400 mg, and 300 mg

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Kalamazoo, Michigan 49001, U.S.A.

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April 19

MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

FOR: Robert E. Paxton, MD, Chairman
MSMS Ways and Means Committee

Doctor Paxton

"Would you please explain what the recent $60 MSMS dues increase is for?"

The MSMS House of Delegates at its May, 1979 meeting approved the $60 dues increase to take effect in 1980. This increase will raise MSMS members' dues to $250 per year, and is effective with the 1980 billings. The increase was recommended by the Ways and Means Committee after it reviewed the present and projected budgets, cash flow analysis and operational reserves in the checking account, as well as inflationary factors. The increase in part will replenish cash reserves. The Ways and Means Committee is making a thorough study this year of the current MSMS method of establishing dues by projecting needs several years ahead. With the economy's fluctuations, this is extremely difficult to do. We will be reporting further to the members.

FOR: Leland E. Holly, II, MD
President, Physician Service Group, Inc.

Doctor Holly

"Is it advisable to have separate office windows for admitting and discharging patients, and if so, why?"

Yes, I recommend setting up a window separate from the admitting desk for discharging patients, and practice management experts agree. This window can be set up either as a separate station or as a distinct section of the same desk area. One purpose in separating these functions is to provide for efficient patient-flow. It is much simpler not to have patients coming and going via the same desk at the same time. Another important purpose is to preserve the patient's dignity by allowing him privacy while he sets his next appointment and discusses fee payment. The result of structuring your office this way will be a more professional and efficient climate for physician, patients, and staff.

FOR: Wilford E. Maldonado, MD
Treasurer, Physician Service Group, Inc.

Doctor Maldonado

"My wife and I filed our wills and trust agreements several years ago and wonder if it is necessary to have them reviewed?"

Yes. Due to changes in probate codes, value of assets and format of documents, it is important that your wills and trust agreements be reviewed periodically. Fee rates can fluctuate within investment corporations and trust customers are often not aware of this. By reviewing these documents one can often find better means for investing his monies. Since lack of attention to this matter can cause hardship to many loved ones, it is important your estate plan be in good order at all times.

Here are winners of photo contest for MS

People of the Region

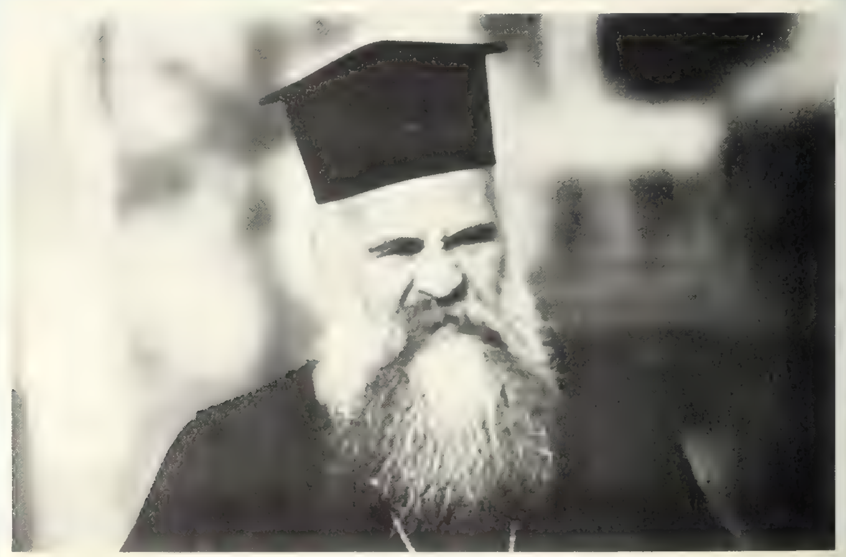
First place, Black and White.

"Grand Place Garçon" Kathryn Bauer, Lathrup Village.

First place, Color.

"Street Cleaner, Greece" C.F. Webb, MD, Grand Rapids

Second place, Color



"Priest" Kathryn Bauer, Lathrup Village

embers, guests on Intrav trips

First place, Color

Scenes

"Gateway of the Gods" Gordon Bartek, MD, East Lansing

First place, Black and White

"Streetlights, Brussels" Kathryn Bauer, Lathrup Village

Special mention goes to Donna M. Chase, Grand Rapids, for her entry, "Mosque on a Foggy Morning."

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WHILE YOU WERE OUT
Urgent!

For doctor, lawyer, merchant, chief, whatever your business, Touch-a-matic is the phone that memorizes your most important numbers for instant contact.

NOW, WITH TOUCH-A-MATIC® PHONES, ONE TOUCH PUTS YO
IN TOUCH, AUTOMATICALLY.

PROBLEM:

You're a busy person, making perhaps dozens of phone calls daily. Many of them are probably directed to the same group of customers. A certain number are probably long distance. And all that calling can take up your valuable time—especially if the number is busy and you have to dial again (up to 11 digits!) with no guarantee that it won't be busy again. The result, for any busy person, can be aggravation and wasted time — plus loss of efficiency.

Now dial one number instead of eleven.

SOLUTION:

The Michigan Bell Team has a solution for businesses that need to streamline their calling. It's called Touch-a-matic® telephone, an automatic dialer that remembers.

The Touch-a-matic dialer remembers up to 31 numbers — local, long distance, or any combination. With the press of a single button, it dials them for you, automatically.

The names and numbers of 31 people, services or offices you call most often can be displayed on the face of the dialer, with no searching or guesswork for you. The numbers the dialer remembers can be entered or changed just as quickly.

The Touch-a-matic telephone is a terrific time-saver. The dialer remembers the last number you dialed manually. If that number was busy, or if you wish to dial it again for any reason, simply press the LAST NUMBER DIALED button and your call goes through.

The Touch-a-matic telephone . . . a way to add new dimensions of efficiency to your business calling. Your Michigan Bell Team, as part of the nationwide Bell System, will be happy to demonstrate the Touch-a-matic dialer for you.

For more information on how the Touch-a-matic telephone might help your business, call toll-free 1-800-482-3820.

**Whatever your business...
The system is the solution.**

Michigan Bell

MSMS goal: to become more aggressive, more positive force — Doctor Ylvisaker

By Shelton Reece
Special to **Michigan Medicine**

"I believe there are two basic functions of the MSMS president," says John R. Ylvisaker, MD, Bloomfield Hills. "They are to represent the entire membership as well as possible and to provide positive leadership in addressing the issues of the day."

Doctor Ylvisaker, who was chosen president-elect in May by the MSMS House of Delegates, sees MSMS as the central, cohesive force for the medical profession in Michigan. MSMS, he says, must meet the responsibilities of the profession in promoting excellent health care, establishing and monitoring ethical standards, providing support and leadership in political processes — as they affect medicine — and responding to the public's great concern about the cost of medical care.

MSMS has task

"As I see it, the society has a substantial task before it — the necessity of becoming a more aggressive, positive force at bargaining tables with politicians, governmental agencies, financing groups, industry, labor and others.

"I hope to help lead the society toward becoming a group to be reckoned with whenever there are deliberations on how health care can most effectively be administered and provided."

Doctor Ylvisaker says he also is very concerned about present methods of paying for health care.

"I sincerely believe that unless each patient has some part of the first responsibility for paying for his/her own medical costs, we will be unable to do much of lasting value in the area of cost containment.

"At the same time, each provider needs responsibilities regarding costs. Ideally, every provider and every patient should have an understanding about costs and what can be done to keep them within reason whenever medical procedures are initiated.

Doctor Ylvisaker

"I see no way that we can continue to provide good health care, or to be realistic about the cost of that care, unless physicians participate as equal partners wherever decisions are made regarding those subjects."

Doctor Ylvisaker was chosen MSMS president-elect in May. He had served as treasurer since 1967. During his tenure, he was responsible for devising and implementing a total revision of asset management and budget processing, and for developing policies for fund maintenance, management and administration.

He also served five years on the board of directors of the Oakland County Medical Society, is a diplomate of the American Board of Surgery (certified in 1957), and fellow of the American College of Surgeons.

The son of a theologian and educator, "Doctor Y," as he is called by many of his colleagues, was born in Decorah, Iowa. He was reared in southern Minnesota where his father was a college president.

"Doctor Y" studied to become a minister, earned a BA at Bethany Lutheran College and did graduate work in theology at Concordia Seminary.

He chose medicine

During the last of eight years required for ordination, he decided that serving people through medical practice was what he most wanted to do. He continued his studies at the University of Minnesota, obtaining BS, BM, and MD degrees there.

Doctor Ylvisaker entered private practice as a general and vascular surgeon in 1955 at St. Joseph Mercy Hospital, Pontiac. He continued in that capacity until 1969 when he was named to his current position as medical director there.

Doctor Ylvisaker is active in Pontiac community activities, particularly the redevelopment of the downtown area. He is co-chairman of New Pontiac Company and has been a member of the Pontiac Stadium Authority. He was one of the founders of the Oakland Health Education Program (probably the largest Area Health Education Corporation in the nation), served as president of the program from 1974 until 1977, and currently is a member of its board of directors. Also, he is a consulting professor of health sciences at Oakland University and is a successful real estate developer.

All the hours that he devotes to work and civic activities notwithstanding, he still finds time to enjoy tennis, jogging, soaring and sailing. He is a well-trained singer and helped finance part of his college years by serving as a choir director.

Foundation for Medical & Health Education elects officers, makes med school grants

Allocations to the Student Aid Committees of Michigan's three medical schools soon will be made by the Michigan Foundation for Medical and Health Education, Inc.

The amounts to be awarded to the student aid committee are awaiting fall enrollment figures at the three medical schools.

In recent actions, however, the foundation has awarded $150 to the Central Hospital Council of Saginaw and $8,350 to the University of Michigan Board of Regents. Both amounts come from the James D. Bruce Fellowship Fund, which the Foundation continues to administer.

Annual income from the General Fund investments of the Foundation were reported at the May annual meeting to be $7,800. A grant of $1,200 to the Michigan Health Council was authorized at the annual meeting, from the general fund. The student aid grants also will come from this amount.

Allocations in previous years were:

	Bruce Fund	**General Fund**
1977	$ 8,144.00	$ 8,348.00
1976	6,900.00	7,998.00
1975	6,300.00	7,400.00
1974	5,150.00	7,400.00
1973	4,300.00	7,200.00
1972	3,497.12	7,600.00
1971	5,091.18	10,800.00
1970	5,188.77	10,383.88
1969	4,511.17	7,825.00

Foundation officers elected in May are Harry A. Towsley, MD, president; Warren F. Tryloff, secretary; B. James Theodoroff, treasurer, and John R. Ylvisaker, MD, vice president for development.

The Michigan Foundation for Medical and Health Education was established in 1945 for the purpose of financing postgraduate and undergraduate education in medicine, for lay health education and for research, fellowships and scholarships.

It is a tax-exempt corporation which uses all of its general fund income in direct grants to the student aid committees of Michigan's medical schools for undergraduate medical education.

The James D. Bruce Fund, a bequest from one of the original board members, is used to support a graduate medical student at the U-M and for the medical libraries of three Saginaw hospitals.

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Letters

"... (I) hope to effect some change in the MSMS stand on this issue."

The support by MSMS of elective abortions continues to astound and trouble me. I find it extremely difficult to understand how physicians, who are trained to heal, can support a procedure whose prime purpose is to destroy life.

We talk about equal opportunity for the poor and ignore the real issue, "abortion." Does the desire of a woman to rid herself of an unwanted pregnancy justify destruction of that child growing within her? Our medical society has never supported the right of poor people to have equal access to chiropractic care, so let's not use that guise with abortion.

No one would suggest that there are not some unfortunate pregnancies but there certainly are alternatives other than abortion. Why do we, as an organization, take such a strong stand in support of abortions? Is it because some of our members partially support themselves by this procedure? I hope not. But it does seem strange that in a state which voted almost 2 to 1 in opposition to abortion, six years ago, our medical society has somehow managed a majority vote in favor of it.

I considered following the lead of one of my colleagues by resigning from the society, but decided to remain in the organization and hope to effect some change in the MSMS stand on this issue. How about a poll of the members?

Respectfully,
Charles T. Vear, M.D.

(Editor's note: The MSMS House of Delegates at its May, 1978 meeting, supported the current practice of state funding of abortions for Medicaid patients, according to the principle that "Medicaid patients should have the same access to medical care as other members of the public.")

"...'My Second Album'..."

It was very nice of you to write that nice article about me in the last issue of *Michigan Medicine*. I have had very favorable comments from many readers and want you to know that the album is doing quite nicely.

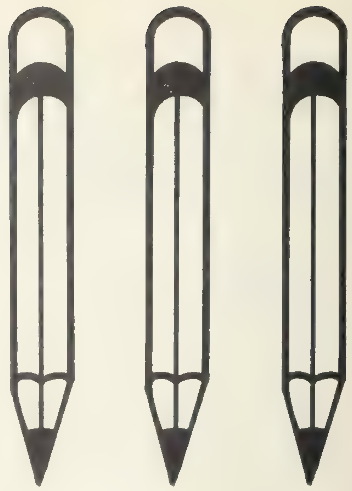
I am almost half finished with my second album, and hope that when it is finished, to call it "My Second Album."

Yvan J. Silva, M.D., F.R.C.S.(C), F.A.C.S.
Associate Professor of Surgery
WSU School of Medicine

"... absolutely enchanting!"

The cover of *Michigan Medicine's* June issue is absolutely *enchanting!* My congratulations to you and Mert Scholten for the best "Year of the Child" photograph to come across my desk.

Dianne Bricker,
Director of Communications
Academy of Medicine of Cincinnati



Letter to Helen

(Editor's note: The following letter was sent recently to Helen A. Schulte of the MSMS staff.)

This is a letter I enjoy writing very much.

At our last meeting, the members of the MSMS Committee on Maternal and Perinatal Health voted unanimously, by acclamation, to make you an honorary member of the committee; our way of letting you know that we consider you one of the team. In this way, we still can have you with us, even though you no longer can continue as our very efficient and appreciated staff assistant because of the press of other responsibilities you have assumed.

Words really are inadequate to express our thanks for all the time, dedication, and friendship you have given to the committee during the 15 years you have worked with us. We hope this honorary membership will serve as a more tangible token of the high regard in which we hold you.

Lee B. Stevenson, MD
Committee Chairman
Detroit

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Take a good look at office setup — is it efficient?

By R. Timothy Hogan, CPBC
Ann Arbor

How long has it been since you really *looked* at your office, cast a critical eye at the physical set-up and considered its equipment and furnishings from the standpoints of efficiency and attractiveness?

Since efficiency is the route to increasing productivity and office appeal is a factor in attracting and holding patients, now is a good time to take a new look at your office.

When you initially moved in, the space probably seemed adequate, you installed modern equipment, and decorated the place nicely. Since then, these things probably have happened:

— Your patient load has grown considerably.

— You have added new personnel.

— You may have brought in an associate to work with you.

Unless you originally took extra space, by now you probably have an office that's short on work and storage space.

"There's a tendency to squeeze too many people and too much equipment into too small an area," says the American Medical Association in its *Planning Guide for Physicians' Medical Facilities*. "The room that has enough floor area to provide space for the equipment and furnishings and leave room to work comfortably without wasted steps is the ideal."

Put your office under the magnifying glass. Begin by trying to see it

---

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

Cast an eye at schedule book — are there problems?

By David L. Laytner
Southfield

What to do with the appointment book may bother the physician almost from the day he or she begins the practice of medicine. I would be delighted to say I can solve scheduling problems here and now, in this article, in the space of a few moments.

The truth of the matter, however, is that it generally takes an in-office consultation to determine *exact* difficulties with scheduling systems. The usual procedure is then for consultant and physician to reason together, and to ultimately arrive at the least painful solution for all parties.

What I intend to do in the brief scope of this article, is discuss some common scheduling difficulties encountered in many practices, and then to offer some suggestions that *may* work in an individual practice.

Remember: if we smooth out scheduling even a small amount, it will be noticed by physician, staff, and most importantly, patients.

Do you ever dread going to the office, because you know a deluge of patients is clustered about the door, waiting to storm the front desk the moment the office door is unlocked? I know a physician who used to delay leaving the hospital for as long as possible, feeling he had to wade through his patients to reach his work area. We solved his attitudinal problem with the simple addition of a separate "doctor's door" at the rear of the office. The solution to his problem of patients loading up during the practice's early hours was almost as simple.

We discovered this particular physician was seeing a few of his patients while he was at the hospital, either during rounds or while examining emergency referral patients. He would often tell them, "You know, this really should be re-checked tomorrow. I'll tell you what: I open my office at 10 A.M. Why don't you stop in first thing in the morning and I'll check you out right away?"

Playing catch-up?

It is easy to see the addition of six or seven patients to the first scheduling hour of the day can have everyone playing "catch-up" all day. The staff is annoyed (a very mild term for what they *really* feel) and the patients are furious! In a situation

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Mr. Laytner is practice management consultant, MSMS/ Physician Service Group.

OFFICE SCHEDULING/*continued*

like this one, all patients except the first will be kept waiting longer than they expect.

A simple solution is for the physician to schedule his hospital-seen patients *throughout* his office day. This evens out the deluge, and placates the office staff. The physician must inform staff that additional patients will be popping in from time to time. The MD may simply jot down name and time after discussing them with the patient at the hospital, and give them to the staff when entering the office.

Practice disjointed?

Some practices are by nature so disjointed and minute-to-minute that little can be done to help their scheduling problems. Any practice that sees large numbers of urgent work-in patients will have a scheduling problem. Pediatrics and orthopedics come to mind.

For practices such as these, we recommend the MD purposely leave 10 or 15 minutes open per hour. Don't fret: you'll fill the time with the patients you never expected to see, and you'll find the day smooths out considerably.

Finally, for multi-physician practices, each doctor should have a daily appointment sheet. We suggest the physician not try to bend a practice-style to fit some pre-printed appointment book, but develop one.

The MSMS/PSG has literally thousands of such suggestions concerning the smooth operaton of practice. As a member service of the medical society, we look forward to helping physicians fill their practice needs, whatever they may be.

OFFICE SET-UP/*continued*

through your patients' eyes. Walk through your reception room, perhaps even sit in a chair. Does it need a fresh paint job? New drapes? Is the carpet or floor covering looking threadbare or shabby? Does the furniture look antique when that wasn't the effect you had in mind? Should you replace it or refurbish it? If children are among your patients or accompany patients to the office, have you provided any small-scale furniture for them, and unbreakable, washable toys or books?

What have you provided to occupy patients while they are waiting? Is fresh reading material at hand? Are lamps and lights adequate and properly placed for reading? Are there prints or paintings on the wall? Is there music to listen to, and perhaps a few green plants to brighten the room? You want to create a restful and homelike atmosphere.

It's important that your receptionist be visible and accessible to your patients. It's equally important that you provide a private spot adjacent to the reception area where a patient can discuss private financial and/or medical matters with your personnel out of earshot of others.

If your reception room passes muster, then take a look at your examining and treatment rooms. Are they freshly painted with equipment that looks clean and modern? Is there a place to hang clothing and set down a purse or package? Are the windows shaded or draped so undressed patients don't feel exposed to viewers from outside? Are doors properly hung to swing so that they provide maximum privacy? Is there reading material, a decent light, and perhaps a place to sit other than on the examining table?

Finally, how's the temperature? Many a patient has shivered under a sheet waiting for the doctor to come into the room, because the temperature is too low. Is the office basically soundproof for privacy?

General scrutiny

Now, scrutinize the office generally from your standpoint. Do you really have enough room in which to practice to your maximum efficiency? Could you effectively use another examining room? Is outward expansion possible to provide another room in which you can see patients? Or, are you short on laboratory space or storage space?

Nowadays there are movable casework walls, already equipped with conduits and plumbing lines that are space-saving and provide additional work and storage space. Sometimes these walls provide a ready answer to your needs.

Now look at the traffic pattern in the office. Is it really as efficient as the space permits? Would shifts in space use of various rooms improve patient flow or minimize steps and maximize efficiency of you and your staff? Would rearrangements of existing furnishings and equipment serve this purpose?

Examine your office next from the viewpoint of your employees. Is their workspace inadequate? Is business and related equipment old-fashioned and consequently slower to operate? Maybe it's time to invest in a new typewriter, a new copy machine, or more up-to-date equipment in the laboratory area. Ask for employees' suggestions; their input can be valuable.

By rearranging, remodelling, refurbishing, and in some instances, refurnishing and replacing things, you'll be doing yourself as well as your patients and employees a favor. You may even discover you can see more patients, because you've eliminated some of those office bottlenecks.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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REFER TO PDR

How to reply when others say MDs earn too much? Here are suggestions

By Elmer White
***Special to* Michigan Medicine**

It's a safe bet that many of your patients resent your income level — at least the income level they think you have attained.

The public has become increasingly sore in recent years over the money it thinks a doctor is paid. Media report after media report has indicated physicians are getting unreasonably rich from insurance payments and charging fees that are too high.

This irritation has been fed by stories of a few doctors who take advantage of Medicaid and Medicare; or who receive a fee "built in" to a hospital service.

We have probably moved away from the point where patients tend to think most doctors overcharge, but that their own doctor is a fine, competent, upright person who does not overcharge.

The disturbing fact is that a growing number of people wonder about the fairness of the charges made by all doctors, including their own.

Doctors who agree with the above are faced with the unhappy problem of what to do about it. To do nothing is to leave a vacuum which can erode physician-patient relationship and increase chances that the public will support some sort of government plan involving fixed fees.

"Doctors make too much money? BALONEY!"

That's the headline on the most recent comparison published by *Medical Economics* of doctors' incomes to other professionals' incomes.

"Doctors do make a lot of money," says *ME*. "The typical physician earned $65,430 from his practice in 1977 . . . But the median income for major league baseball players is $68,000.

"There are plenty of lawyers, corporate executives and other professionals whose earnings are right up with those of physicians. Both corporate executives and corporate attorneys are ahead of MDs in hourly pay."

"Airline pilots . . . really do well on the hourly pay scale." Physicians' hours on call balance pilots' hours on ground during layovers or standby time, continues *ME*.

"And," suggests Marianne Dekker Mattera, *ME* senior associate editor, "though (the pilot) may hold the lives of people in his hands, too, (tell him) it takes you 23 years of formal education and a lifetime of continuing education to qualify for your job."

Most doctors not overpaid

Yet there is much to indicate that most doctors are not overpaid for their services.

This is a point doctors have failed to communicate to their patients. In fact, most physicians might consider it a breach of their privacy to discuss their incomes with anyone; even in the most general of terms.

The first step is for the doctor to know his income and not be ashamed or embarrassed by it.

The second step is to get the doctor's income in perspective.

For example, the pay rate for major league umpires was just set. This shows that experienced umpires, who work less than half the year, will be paid as much as $50,000 per year. Starting umpires get $22,000. A fine load of fringes is added to that base pay.

The published pay scale for a third assistant on a Great Lakes freighter makes another interesting comparison. This can be a young man fresh from a four year maritime school course. For 300 days' work per year he is paid $46,545. The schedule shows that after one year this goes to $51,161; after two years to $57,571. The list of fringes includes everything imaginable, including the right to have his family sail with him for up to four weeks and a pension plan which pays 50 per cent of salary after working for 25 years.

Doctors can easily become aware of wage scales in their own areas. Lawyers, bankers, some merchants, salesmen; executives of industry; even government officials often earn more than the local doctor.

Long training, hours important

Doctors need to remember and remind others of the many years they worked to secure training which fits them for their service to the public: the long hours of the "public service" which is required of them on hospital committees and in training young doctors; the residence days; the long hours of their routine day

(Continued on page 432)

Mr. White, former executive director of the Michigan Press Association, serves as media relations consultant to MSMS.

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INDICATIONS: *Therapeutically,* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

INCOMES/*Cont.*

and the pressures of being called at any hour.

Patients need to be more aware of the expenses of medical training; that most medical students graduate owing substantial amounts of money and the need for much more to start in practice.

Most of all, patients need to understand that what they get in medical treatment and advice is worth much more than they are charged and that the present system of delivering medical service in this country makes more physicians available to more people more of the time than in any other nation.

Since doctors have the most to lose if the economic facts about medical service are not understood by the public, it is up to doctors to see that every effort is made to bring about that understanding. Such an effort should be part of every doctor's everyday work.

Doctors must develop ways to communicate the main points. They must be willing to mention some of these things to patients, friends or critics. It might be professionally satisfying to remain aloof from such basic discussion, but it is also losing opportunity to inform the public and protect the profession.

Licensed Michigan MDs increase

The table below, based on Michigan Cooperative Health Information System data, shows an increase of physicians licensed and practicing in Michigan.

While the total number of doctors licensed has increased by over 1,100, the out-of-state category has remained relatively constant. This is the first year physicians practicing out of the country have been included in this report.

The data are based on licensure records obtained on completion of the annual January 1 renewal.

NUMBER OF MEDICAL DOCTORS LICENSED BY MICHIGAN

	Year of Licensure			
Location	*1975*	*1976*	*1977*	*1978*
Total Number Licensed	15,211	15,668	15,558	16,708
MICHIGAN	11,098	11,237	11,703	12,485
Out-of-State	4,113	4,432	3,855	3,879
Out of Country	—	—	—	344

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Or write: **Physician Service Group, Inc.**
1305 Abbott Rd.
East Lansing, MI 48823

Countersuits continue to see difficulties

(Editor's note: MSMS Legal Counsel A. Stewart Kerr has suggested reprinting of this description of a recent countersuit ruling from the April 15 issue of the AMA's legal newsletter, "The Citation," Vol. 39, No. 1, p. 1.

Physicians lose countersuit

Two physicians lost their countersuit against two attorneys and a patient, and an Illinois appellate court affirmed the decision.

In January 1974, one of the physicians, who operated a free clinic, removed a skin growth on the nose of the patient by electrodesiccation. The next day the patient saw an otolaryngologist who was in private practice and not associated with the first physician. She told the specialist that the physician had removed the growth some six weeks earlier. The specialist then performed further surgery and a skin graft in the same area.

In May 1974, the patient met with two attorneys complaining of the scar on her nose and difficulty she was having with her vision and sense of smell. The attorneys made a preliminary investigation of her claim, and then filed suit against both physicians in June 1974. The patient did not appear when the case was called for trial in October 1975. The trial court denied several motions by the attorneys and then entered judgment in favor of the physicians.

The two physicians then filed a countersuit against the two attorneys and the patient. They sought recovery for alleged negligence and malicious prosecution. A trial court entered judgment for the attorneys, and the physicians appealed.

Affirming the decision, the appellate court said that the physicians could not maintain the action for alleged negligence in filing the malpractice action. In addition, the physicians had not suffered any of the special damages necessary to maintain the action for malicious prosecution, the court said. — *Balthazar v. Dowling*, 382 N.E.2d 1257 (Ill. App. Ct., Nov. 15, 1978)

Editor's Note: A previous decision in this case was reported in THE CITATION, Vol. 34, No. 11, p. 127.

These Michigan cases summarized in AMA's *Citation* (See issues cited for further details)

No Negligence in Vasectomy and Postoperative Care, Michigan Court of Appeals, April 3, 1978, from the Citation, Vol. 37, No. 12.

Suit Against Physicians for Failure to Diagnose Cancer Not Barred by Time Limits, Michigan Court of Appeals, April 18, 1978, from the *Citation,* Vol. 37, No. 12.

State Law for Release of Mental Patients Challenged, District Court, Michigan, Feb. 24, 1978, from the *Citation,* Vol. 37, No. 12.

Michigan Court Upholds Parents' Suit for "Wrongful Pregnancy," Michigan Court of Appeals, May 22, 1978, from the *Citation,* Vol. 38, No. 1.

Terminated Nurse Has No Civil Rights Action, District Court, Michigan, March 29, 1978, from the *Citation,* Vol. 38, No. 1.

Modification of Michigan No-Fault Insurance Act, Michigan Supreme Court, June 8, 1978, from the *Citation,* Vol. 38, No. 2.

Hospital and manufacturer sued for allegedly bad intravenous solution, Michigan Court of Appeals, July 18, 1978, from the *Citation,* Vol. 38, No. 9.

City hospital immune from suit, Michigan Court of Appeals, May 23, 1978, from the *Citation,* Vol. 38, No. 9.

Hospital not immune from suit for fall on entrance sidewalk, Michigan Supreme Court, August 30, 1978, from the *Citation,* Vol. 38, No. 9.

Municipal hospital immune from suit for negligence, Michigan Court of Appeals, May 10, 1978, from the *Citation,* Vol. 38, No. 9.

Legal and medical malpractice suits share statute of limitations, Michigan Court of Appeals, August 7, 1978, from the *Citation,* Vol. 38, No. 9.

Attorney's reinstatement improperly denied, Michigan Supreme Court, August 30, 1978, from the *Citation,* Vol. 38, No. 10.

"$120,000 Award Against Hospital For Negligent Treatment of Dislocated Shoulder," December 28, 1978, Michigan Supreme Court, from the *Citation,* Vol. 39, No. 4.

"Manufacturer of Dye Not Liable For Death of Patient After Reaction," Michigan Supreme Court, January 10, 1979, from the *Citation,* Vol. 39, No. 4.

"Health Systems Agency Held Exempt From Antitrust Law," District Court, Michigan, March 2, 1979, from the *Citation,* Vol. 39, No. 4.

"No Governmental Immunity for City-Owned Hospital," Michigan Supreme Court, December 27, 1978, from the *Citation,* Vol. 39, No. 4.

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MEDICO-LEGAL/*continued*

Team physicians now at great risk of malpractice suits

Here's an interesting aspect of the medical malpractice situation. It should be of particular interest to Michigan team physicians.

(Editor's note: The following article is reprinted with permission from the April 30, 1979 issue of Malpractice Life Line.*)*

Pro football players, washed up because of injuries on the playing field, are suing team physicians in increasing numbers.

The malpractice suits are driving more sports doctors out of the NFL. Those who stay are finding they can no longer buy malpractice insurance at any price. In California, word is that only one company will still write coverage for team doctors.

Even college and high school sports are beginning to feel the pinch as fewer physicians are willing to make themselves available to provide medical advice or on-scene treatment to players who get hurt.

Charles Bricker, *San Jose Mercury* writer, analyzed the "lawsuit binge" aimed at sports medics in a three-part series in that newspaper. The partial litany of suits he cited included:

— Former Chicago Bears linebacker Dick Butkus' suit against the team and its physician, Theodore Fox, MD, alleging that improper medical treatment put him on the sports sidelines permanently. Butkus won a $600,000 jury victory.

— Former Oakland Raider running back Bill Enyart's 1977 suit against team doctor Robert Rosenfeld, MD. Enyart won $200,000. Rosenfeld's malpractice insurance, pegged at $7,000 in 1978, jumped to $32,000; now nobody will sell it to him. He's "bare."

— Defensive lineman Bubba Smith's $2.5 million suit against the NFL. The well-travelled Smith lost the suit in a Tampa, Fla. federal court in February, 1977, but he's appealing.

"Pro footballers, their careers endangered and ended by serious injury, visions of million-dollar contracts drying up like exhausted unemployment insurance checks, are suing anyone whose pockets jingle," says Bricker.

"While everyone from trainers to NFL executives have been defendants in suits brought by team athletes, it is team physicians who are most vulnerable."

Unless something is done to check the spate of athletic malpratice suits, Jim Garrick, NFL orthopedic consultant, says sports medicine is going to become "very, very conservative. Doctors will not recommend athletes play with even minor injuries."

Act 119 of the Public Acts of 1975

AN ACT to amend sections 1, 2 and 3 of Act No. 270 of the Public Acts of 1967, entitled "An act to provide for the release of information for medical research and medical education purposes; to limit the liability with respect thereto; and to safeguard the confidential character thereof," being sections 331.531, 331.532 and 331.533 of the Compiled Laws of 1970.

The People of the State of Michigan enact:

Sections amended; release of information for medical research and education.

Section 1. Sections 1, 2 and 3 of Act. No. 270 of the Public Acts of 1967, being sections 331.531 and 331.532 and 331.533 of the Compiled Laws of 1970, are amended to read as follows:

331.531 Providing information to review entity regarding person's physical or psychological condition; "review entity" defined; liability. [M.S.A. 14.57(21)]

Sec. 1. A person, organization, or entity may provide information or data relating to the physical or psychological condition of any person, or the necessity, appropriateness, or the quality of health care rendered to any person, to any review entity. Review entity means a duly appointed peer review committee of the state, of a state or county association of health care professionals, of an officially constituted health care facility, or of a health care association; a professional standards review organization qualified under federal or state law; a foundation or organization acting pursuant to the approval of the state or county medical society; or a state department or agency whose jurisdiction encompasses such information. Liability of any kind shall not arise or be enforced against any person, organization, or entity by reason of having provided such information or data; by reason of any act or communication within its scope as a review entity; or by reason of having released or published the proceedings, reports, findings or conclusions of the review entity subject to the limitations of sections 2 and 3. The immunity in this section shall not apply to a person, organization, or entity that acts with malice.

331.532 Review entity; release or publication of proceedings, reports, findings, and conclusions. [M.S.A. 14.57(22)]

Sec. 2. The release or publication of the proceedings, reports, findings and conclusions of any review entity shall be for 1 or more of the following purposes:

(a) To advance health care research or health care education.

(b) To maintain the standards of health care professions.

(c) To protect the financial integrity of any governmentally funded program.

(d) To provide evidence relating to the ethics or discipline of any individual or entity engaged in the practice of medicine or health care.

331.533 Confidentiality. [M.S.A. 14.57(23)]

Sec. 3. The identity of any person whose condition or treatment has been studied shall be confidential and such person's name and address shall be removed from the record before the review entity releases or publishes its proceedings, reports, findings and conclusions, and, except for the purposes set forth in section 2, all proceedings, reports, findings and conclusions of review entities under this act are confidential and shall not be discoverable or used as evidence in an action for personal injuries based upon malpractice, lack of informed consent or negligence.

Approved June 25, 1975.

This document prepared by Kerr, Russell & Weber, Legal Counsel to the Michigan State Medical Society.

Public Act 119
of 1975
Means

You are immune from liability of any kind (malpractice, slander, negligence, libel or interference with contractual relations) when you 1) Sit as a member of a peer review entity, or 2) Provide information to a peer review entity.

Here's how . . .

(Please turn page)

The following sets forth a summary of the statutory protection set up in P.A. 119.

• Who is protected?

1. Any person or entity that provides information to a review entity.

2. Any person or entity that acts or communicates within a review entity.

3. Any person or entity that releases or publishes the proceedings, reports, findings or conclusions of a review entity.

• What is the protection?

The protection is immunity from liability of any kind (such as malpractice, libel, slander, negligence and interference with contractual relations) by reason of the protected activities above.

• What are the limitations?

1. There is no immunity for any person or entity that acts with malice.

2. The information must be furnished to a review entity and relate to one of the following general topics:

(a) The physical or psychological condition of any person, or

(b) The necessity, appropriateness or the quality of health care rendered to any person.

3. Acts or communications of the members of the review entity must be within the scope of the review entity.

4. The release or publication of the proceedings, reports, findings or conclusions of the review entity must be for one or more of the following purposes:

(a) To advance health care research or health care education,

(b) To maintain the standards of the health care professions,

(c) To protect the financial integrity of any governmentally-funded program,

(d) To provide evidence relating to the ethics or discipline of any individual or entity engaged in the practice of medicine or health care.

• What is a review entity?

A review entity is one of the following:

(a) A duly-appointed peer review committee of a state or county association of health care professionals, of an officially-constituted health care facility, or of a health care association,

(b) A professional standards review organization qualified under federal or state law,

(c) A foundation or organization acting pursuant to the approval of the state or county medical society,

(d) A state department or agency whose jurisdiction encompasses such information.

• What protection is afforded to the physician whose actions are in question?

Except for the four specific purposes set forth under limitations above, all proceedings, reports, findings and conclusions of review entities are:

1. Confidential,

2. Not subject to discovery,

3. Not admissible in evidence in an action for personal injuries based upon malpractice, lack of informed consent or negligence.

• What protection is afforded to the patient?

The identity of the person whose condition or treatment has been studied is confidential, and such person's name and address must be removed from the record before the review entity releases or publishes its proceedings, reports, findings or conclusions.

Meetings

Of AMA, MSMS

Aug. 27-Sept. 1 — AMA Special Joint Session on Medical Staff Leadership and Conflict Resolution, Wentworth-by-the-sea, Portsmouth, NH, contact: AMA Department of Negotiations, 312/751/6647.

Sept. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 24 — MSMS Conference on State Legislation, contact: Bruce Ambrose, MSMS headquarters.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters, 312/751/6000.

Dec. 12 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS headquarters.

Other Meetings

Sept. 23-26 — Toxic Substances in the Human Food Chain: Implications for Public Health Practice, University of Michigan Extension Service, Radisson-Cadillac Hotel, Detroit, contact: Jane Elgass 313/764/5307.

Sept. 25 — Transition: The Challenge, Council on Continuing Education of the American Nurses Association, University of Michigan, Ann Arbor, contact: Elizabeth A. Allen, RN, Associate Professor of Nursing, 1355 Catherine Street, Ann Arbor, 48109.

Oct. 12-13 — La Leche League of Michigan, 13th Annual Fall Conference, "The Right of the Child to Good Mothering through Breastfeeding," Delta College, Saginaw, MI, contact: Sue Stamp, AACS, 10345 West R Ave., Mattawan, MI 49071 (send 35¢ to cover postage and handling for bulletin).

Oct. 13 — Michigan Speech Pathologists in Clinical Practice, 9th Annual Workshop, "Coping with a Communication Disorder: Effect on Client, Family and Speech/Language Pathologist," Mercy Center, 28600 Eleven Mile Road, Detroit, MI 48230, (891-5570).

BEGGING YOUR PARDON . . . Acknowledgement was omitted for the table on the correct schedule of immunizations for adolescents, which was printed on page 292, in the June, 1979 issue of *Michigan Medicine.* The table was printed with the permission of Richard R. Brookman, MD, Cincinnati Children's Hospital Medical Center. Our gratitude goes to Doctor Brookman for use of the table.

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Category I courses

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Aug. 24-27, Infectious Diseases and Rheumatology. Location: Grand Hotel, Mackinac Island. **Sponsor:** Towsley Center for CME, University of Michigan. **Cost:** $150. **Contact:** Floyd C. Pennington, PhD, director, Office of CME, University of Michigan Medical School, Towsley Center, Ann Arbor, 48109. **Approved for:** 11 hours of Category I Credit.

Date: Aug. 29, E N T and the Family Physician. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital Dept. of Family Practice. **Cost:** No Charge. **Contact:** Jean Machtel, CME Coordinator, E. W. Sparrow Hospital, 1215 E. Michigan Avenue, Lansing, 48909, Phone: 517/487-2790. **Approved for:** 4 hours of Category I Credit.

Date: Sept. 7-8, Blood Transfusions. Location: Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pathologists. **Cost:** $135. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 9½ hours of Category I Credit.

Date: Sept. 7-9, Diagnostic Ultrasound. Location: University of Michigan, Ann Arbor. **Sponsor:** Towsley Center for Continuing Medical Education. **Cost:** $160., physicians; $95., physicians-in-training; $95., technologists. **Contact:** Floyd C. Pennington, PhD, Director, Office of Continuing Medical Education, U-M, Ann Arbor 48109. **Approved for:** 16 hours of Category I credit.

Date: Sept. 8, Diagnostic Problems in Neuropathology. Location: St. John Hospital, Detroit. **Contact:** T. A. Reyman, MD, Dept. of Pathology, Mt. Carmel Mercy Hospital, Detroit, or John G. Batsakis, MD, Dept. of Pathology, University of Michigan Medical Center, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: Sept. 10-Nov. 12, Pediatric Seminar IV. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 20 hours of Category I Credit.

Date: Sept. 13-14, The Michigan Association of Blood Banks Annual Scientific Meeting. Location: Plymouth Hilton, Plymouth. **Sponsor:** Michigan Association of Blood Banks. **Co-Sponsor:** Pontiac General Hospital. **Cost:** Members, 1-day, $10, two-days, $20; Non-members, 1-day, $15, two-days, $30. **Contact:** Miss Ruth Kroepel, Central Office Manager, 17150 Bentler #201, Detroit, 48219. **Approved for:** 11 hours of Category I Credit.

Date: Sept. 14-15, Clinical and Radiological Evaluation of Athletic Injuries. Location: Kellogg Center, East Lansing. **Sponsor:** Michigan State University departments of Radiology and Athletic Medicine. **Cost:** $100. **Contact:** Thomas S. Arle, MD, Department of Radiology, MSU, B220 Clinical Sciences Building, East Lansing, 48824. **Approved for:** 10 hours of Category I Credit.

Date: Sept. 17-21, 6th Annual Family Practice Review. Location: Wayne State University School of Medicine, Scott Hall, Detroit. **Sponsor:** Wayne State University School of Medicine. **For:** Family Physicians. **Contact:** Wayne State University School of Medicine, Division of CME, 1206 Scott Hall, Detroit, 313/577-1180. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 19-21, Real Time Ultrasound for the Private Obstetrician/Gynecologist. Location: Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** Department of Obstetrics and Gynecology. **Enrollment:** Limited to 25, pre-registrants only. **Cost:** $500. **Contact:** Towsley Center for Continuing Medical Education, Ann Arbor. 313/764-2287. **Approved for:** 21 hours of Category I credit.

Date: Sept. 20-22, Midwest Cancer Seminar. Location: The Concourse, Madison, Wis. **Sponsor:** Wisconsin Clinical Cancer Center, Center for Health Sciences Midwest Children's Cancer Center, American Cancer Society — Wisconsin Division, Eastern Cooperative Oncology Group, and Cancer Education Committee of Wisconsin Clinical Cancer Center. **For:** Physicians engaged in primary care and oncology-related specialties. **Cost:** $58. **Contact:** Wisconsin Clinical Cancer Center, 1900 University Ave., Madison, WI 53705, 608-263-6919. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 25-26, Dr. Cyriax — Orthopedic Evaluation. Location: Northland Inn, Southfield. **Sponsor:** Michigan Physical Therapy Association, Eastern District; The Department of Rehabilitation Medicine, Sinai Hospital of Detroit. **For:** Orthopedists, rheumatologists, physiatrists, family physicians, internists and physical therapists who are daily involved in the care of patients with orthopedic disorders. **Cost:** $85. **Contact:** Sharon Ferrara, RPT, % A.P.T.A., 9832 Cranston, Livonia, 48150. **Approved for:** 14 hours of Category I Credit.

Date: Sept. 26, Diabetes Update. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Sept. 27-30, American Medical Association Regional Meeting. Location: Sawmill Creek Lodge, Huron, Ohio. **Sponsor:** Ohio State Medical Association. **Cost:** $85 per course. **Contact:** Department of Meeting Services, AMA, 535 North Dearborn Street, Chicago, IL 60610, 312/751-6000. **Approved for:** 5 credit hours per course, 1 course per day.

Date: Sept. 29-30, Burns Clinic/Northern Michigan Hospitals 7th Annual Medical Meeting. Location: Holiday Inn, Traverse City. **Sponsor:** Burns Clinic Medical Center P.C. and Northern Michigan Hospitals, Inc. **For:** All physicians. **Contact:** G. A. Uhlich, MD, Education Committee Chairman, Northern Michigan Hospitals, Inc., Traverse City, 49684. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 3-5, Blood Coagulation: Clinical and Laboratory Aspects. Location: Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Education. **For:** Physicians with a major interest in hemostasis. **Cost:** $190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 22½ hours of Category I Credit.

Date: Oct. 5-7, Michigan Regional Meeting, American College of Physicians. Location: Boyne Highlands, Harbor Springs. **Sponsor:** Michigan Chapter American College of Physicians. **For:** All interested physicians. **Cost:** $25. **Contact:** Boy Frame, Governor, Michigan Chapter American College of Physicians, Henry Ford Hospital, 2799 W. Grand Boulevard, Detroit, 48202. 313-876-2373. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 5-7, Anesthesia and the Circulation. Location: The Homestead, Glen Arbor. **Sponsor:** Michigan Society of Anesthesiologists and the U-M Anesthesiology Dept. **For:** Anesthesiologists. **Cost:** $75. **Contact:** University of Michigan, Dept. of Anesthesiology, F 3820, Mott Hospital, Ann Arbor, 48109, 313/763-2435. **Approved for:** 9 hours of Category I Credit.

Date: Oct. 18-19-20, Implant Surgery for Joints and Tendons in the Hand. Location: Blodgett Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand, Blodgett Memorial Medical Center. **Cost:** $250. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. 616/774-0440. **Approved for:** 19.5 Category I credits.

Date: Nov. 1, MSU Family Practice Research Day. Location: University Club, Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine. **For:** Family Physicians. **Cost:** $30. **Contact:** Douglas McKeag, MD, Department of Family Practice, MSU College of Human Medicine, B-100 Clinical Center, East Lansing 48824. 517/353-0850. **Approved for:** 8 hours of Category I Credit.

Date: Nov. 5-9, Principles of Milieu Practice: Working With the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** Institute of Gerontology. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 E. Liberty Street, Ann Arbor. 313/763-4101. **Approved for:** 30 hours of Category I credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 28, Updating Core Knowledge in General Surgery. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: **Dec. 8, Seminar on Diagnostic Problems in Gynecologics, Soft Tissue, and Male Genitourinary Tract Pathology. Location:** University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Dr. T. A. Reyman, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, Michigan or Dr. John G. Batsakis, Department of Pathology, University of Michigan Medical Center, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: **Jan. 16, 1980, Hypertension. Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236. (313/343-4000). **Approved for:** 8 hours of Category I credit.

Date: **March 19, 1980, Infectious Diseases in Obstetrics and Gynecology. Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: **May 21, 1980, Medical Therapy in Family Practice. Location:** Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

International conference on effects of toxic substances planned Sept. 23-26 in Detroit

A national conference of value to all professionals concerned about the introduction of toxic substances into the human food chain, and resultant effects on human life, is planned Sept. 23-26 in Detroit.

The event has been months in planning and will feature talks by an international array of experts.

"Toxic Substances in the Human Food Chain; Implications for Public Health Practice," is the topic of the event, which will take place at the Radisson-Cadillac Hotel. Sponsors are the Michigan and American Public Health Associations, with support from the State of Michigan. The University of Michigan Extension Service is cooperating.

The registration fee is $100 per person. Chairperson is Ralph E. Lewis, executive director, Michigan Medical Schools Council of Deans.

Sessions are planned on food production, food processing, human health, education, and policy.

Registration and other information is available from the Michigan Public Health Association, 403 Seymour, Lansing, 48914 (tel: 517/484-3044).

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Annual Scientific Meeting Nov. 13-14-15

Nearly every major specialty plans courses at MSMS event

Whether you're a superspecialist in a field like neurosurgery, or a family physician, there is something planned for you at the 1979 MSMS Annual Scientific Meeting.

The big event is scheduled Nov. 13-14-15 at the Hyatt Regency Dearborn, where meeting facilities and neighboring attractions are the best, providing opportunities for a mini-vacation as well as further education.

Nearly every major specialty society in Michigan is planning at least one course among the 56 three-hour Category I sessions which will be offered.

In some cases, a physician may spend the entire three days attending courses on a single subject.

In other cases, a specialist may plan a full day of courses in his or her field, and round out the rest of the Annual Scientific Meeting with samplings in areas needing brush-up.

Psychology of illness

Supposing you'd like to study further the psychological implications of illness. An outstanding array of courses are planned probing mind and disease together. They are:

"Preventing Physician Suicide through Early Recognition and Proper Care," Tuesday morning, presented by the MSMS Committee to Assist Impaired Physicians;

"Use of Psychoanalytic Knowledge in Medical Practice," Tuesday afternoon, the Michigan Psychoanalytic Society;

"Stresses within the Physician's Family," Wednesday morning, the Michigan Psychiatric Society and the MSMS Auxiliary;

"Psychological Problems of Critically-Ill Patients," Wednesday afternoon, the MSU Department of Psychiatry;

"Psychology of Abortion," Wednesday afternoon, Michigan Psychiatric Society;

"Medical Ethics Workshop," Thursday morning, MSMS Task Force on Medical Ethics;

"Understanding and Treating Alcoholism and Drug Dependence," Thursday morning, with national authority Richard C. Bates, MD, Lansing, who also is a contributing editor to *Medical Economics* magazine.

Pulmonary and heart

Again, respiratory problems, pulmonary and heart disease are given the full treatment, with a spectrum of courses during the Annual Scientific Meeting:

"Alpha-Omega Session: Overview of Pulmonary Diseases in Children, Adults and Elderly Patients," Tuesday morning, director Samuel M. McMahon, MD, MSU College of Human Medicine and Ingham Medical Center. Doctor McMahon is chairman of the entire Annual Scientific Meeting program.

"Mechanical Ventilation in Acute Respiratory Failure — Newer Techniques," Wednesday morning, presented by the Pulmonary Division. University of Michigan;

"Gastrointestinal and Pulmonary Endoscopy: A Review," Tuesday afternoon, the MSU College of Human Medicine Department of Medicine;

"Changing Concepts in Evaluation and Therapy of Coronary Artery Disease," Thursday afternoon, WSU School of Medicine;

"New Concepts in Congestive Heart Failure," Thursday morning, MSU College of Human Medicine;

"Preventive Cardiology — The Primary Care Mission," Thursday morning, MSU Department of Human Development;

"Current Concepts in the Medical and Surgical Management of Ischemic Heart Disease," Thursday afternoon, Michigan Chapter, American College of Chest Physicians;

"Ventricular Premature Beats: Their Significance and Current Therapy," Thursday afternoon, Michigan Chapter, American College of Physicians.

Physicians interested in the new body imaging techniques and instruments might schedule courses each afternoon. Tuesday PM the course is "The Use of CAT-Scan in Making a Diagnosis Economically," sponsored by the MSU Department of Radiology. Wednesday PM the course is "Nuclear Medicine — Its Practical Value," by the Michigan College of Nuclear Medicine Physicians. Thursday afternoon the course is "Imaging Use in Clinical Medicine," presented by the Michigan Radiological Society.

Specialties schedule days

A full day of courses on diabetes is planned Tuesday, and industrial physicians plan a day devoted to industrial and environmental pollutants, and chronic low back pain.

On Wednesday, physicians may spend the full day studying asthma, dermatology, pediatrics, urology, otolaryngology and plastic surgery.

On Thursday, ophthalmologists have a full day of courses.

Advanced Cardiac Life Support courses run all day Wednesday and Thursday.

All of the courses are planned with the family physician in mind, and in cooperation with the Michigan Academy of Family Physicians. AAFP prescribed credit will be awarded for all but one, in addition to the Category I credits.

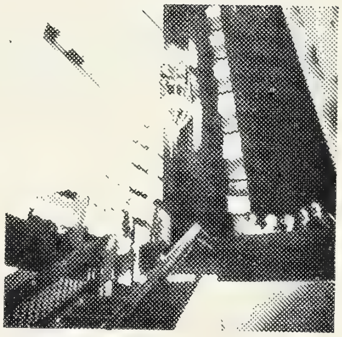
A full list of courses appears in the June 22 *Medigram* newsletter, and further information is available from Sherry Fent at MSMS headquarters.

Michigan State Medical Society

The study of medicine is a life long commitment to the art of healing.

You can continue your medical education by choosing from 56 one-half day CME courses being offered by the Michigan State Medical Society at the Annual Scientific Meeting November 13, 14, 15.

The Meeting takes place at the Hyatt Regency in Dearborn. It's connected by monorail to Fairlane mall and is only minutes away from historic Greenfield Village. So while the meeting is a learning opportunity for you, it can be a mini-vacation for your spouse.



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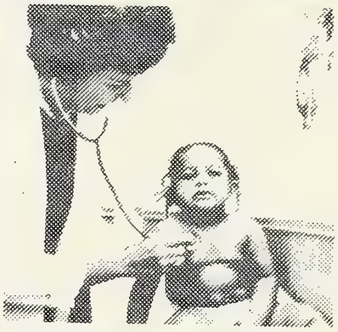
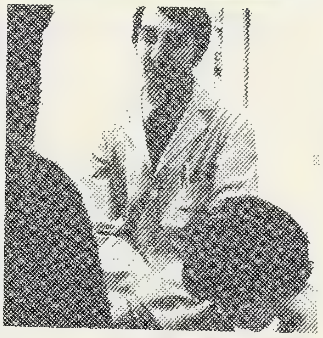
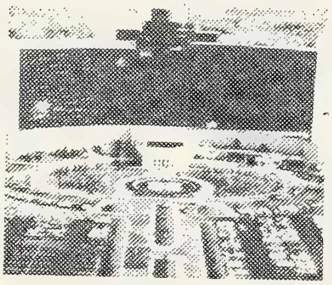
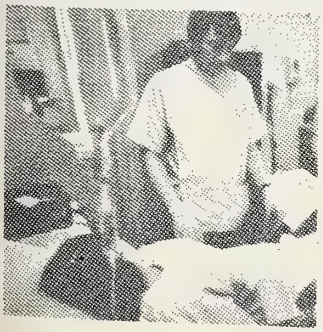




Physicians analyze, evaluate, advise — they don't work magic

Need new image

The successful practice of medicine is a mixture of science, art and a little luck, all needed to deal with health problems, some of which have no happy solution. Physicians should help the public understand they are analyzers, evaluaters, advisers, rather than magicians who can conjure up mysterious remedies.

By Elmer E. White
MSMS Media Relations Consultant

Too many people consider a physician a combination of Doctor Welby, who always has time and temperament to deal successfully with any medical problem, and a sorcerer who, if he only tries hard enough, can cure any disease or condition.

This inaccurate image has not been exactly discouraged by some doctors over the years. It is understandably ego-satisfying to be held in such awe.

A new image

But this is an image which physicians should no longer permit. It would be much better for patients and doctors alike if physicians would make conscious efforts to create a new and more accurate image.

The new concept should be that of a guide who shows people the best way to get through a jungle, avoiding dangerous animals and swamps; or a harbor pilot who comes aboard to direct a ship's journey to a safe docking through waters filled with hazards; or a quarterback, who must analyze formations of an opposing team, then find the best combination of plays to win against them.

These new image examples have one thing in common. They present the physician as a person helping attain a goal against obstacles; someone familiar with dangers who understands risks; someone who is specially suited to help. But they don't present an infallible person.

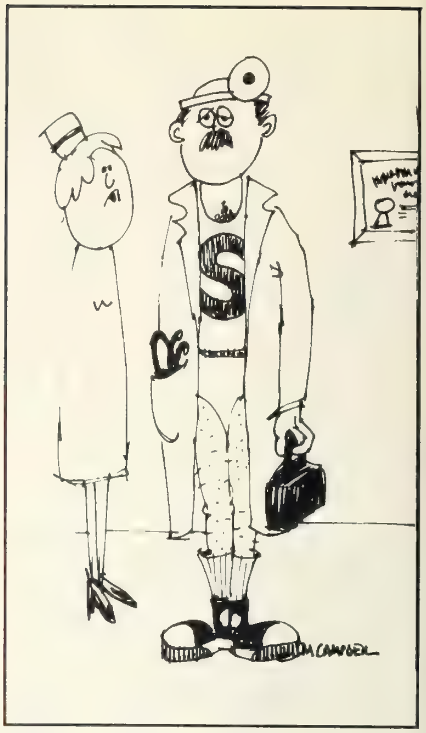
Doctors understand their skills are not unlimited; but many patients do not, or do not want to. It is, on the one hand, reassuring for a patient if he thinks the doctor has a sure cure for every ailment; but it is a distressing emotional blow when he is forced to realize this is not the case.

In such an atmosphere the physician risks the danger that patients think he does not care enough or is too lazy to effect a cure.

Healthier respect

The successful practice of medicine is a mixture of science, art and a little luck, all needed to deal with health problems, some of which have no happy solutions. Physicians should help the public understand they are analyzers, evaluaters, advisers, rather than magicians who can conjure up mysterious remedies.

When patients have this clearer understanding of the doctor, there can be a healthier respect between the two. Such respect can place doctors in the position of people who apply all their talents and abilities to deal with a medical problem; and help patients understand that even the best of all courses selected cannot always guarantee complete recovery.



"You can't fool me, Doctor."

It is up to physicians to help people see doctors as they truly are.

AMA offers model bill on death determination

Passage of state laws which permit physicians to determine death by cessation of brain function is important to facilitate availability of kidneys and other organs for transplant.

For guidance of states wishing to consider such legislation, the AMA has drafted a model bill which reiterates the prerogative of the physician to declare an individual dead in accordance with accepted medical standards, one of which is irreversible cessation of brain function.

Copies of the AMA model bill have been provided to state medical societies. Some 21 states have already adopted legislation on this issue, including Michigan.

Doctors, nurses complement each other in joint medical practice setting

By Charles R. Downs
Special to Michigan Medicine

"The doctor does the doctor thing and the nurse does the nurse thing and together they provide better patient care," says Richard Henderson, MD, Detroit physician and former chairperson of the Michigan Joint Practice Commission.

And that, basically, is what joint practice is all about — doctors making good use of their special abilities to diagnose and treat disease and the nurses using their special abilities to examine, observe, counsel and educate to best advantage.

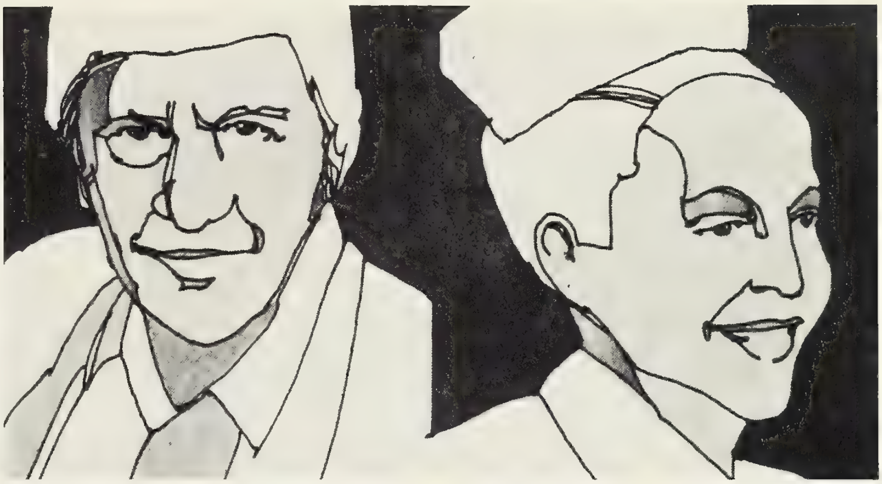
"The nurse is more apt to be health-oriented and the doctor more disease-oriented," notes Doctor Henderson. "They complement each other."

Even though joint practice has become a new topic in health circles, joint practice itself is not new, according to a member of the Michigan Nurses Association staff.

"Doctors and nurses have been practicing together ever since there have been nurses," says Elizabeth Peckham. "Most doctors," she adds, "work well with nurses and have enormous expectations of them."

Nurses' contributions

But, adds Ms. Peckham, many doctors have not recognized the contributions nurses make to the care of patients in hospital, home and ambulatory settings. She notes that doctors trust nurses to make good observations and to know what to do for many patients without being explicitly told. Still, she adds, it often comes as a surprise to doctors to find that nurses are specifically trained and legally qualified to do many of those things.



What is formerly called joint practice today involves explicit recognition and definition of the respective roles and strengths of doctors and nurses. This involves not only the doctors and nurses but also the patients, who learn that they can and should see the nurse in some situations and the doctor in others.

The precise roles of doctors, nurses and patients in joint practices vary widely.

In Howell, for example, Joint Practice Commission member Carolyn Creighton, MD, is one of seven physicians in a group practice that involves two nurses as practitioners/clinicians.

One of the nurses, Geraldine Bourlier, has been trained in pediatric practice and handles what is basi-

The successes of joint practice have led to the support of the Michigan Joint Practice Commission by MSMS and the MNA. The commission recently issued a "Statement of Joint Practice," which defines and sets up some guidelines for joint practice.

Completion of special training beyond licensure is required by Michigan law to qualify a registered nurse as "nurse practitioner." The American Nurses Association equates the nurse practitioner and nurse clinician as one and the same, with the same scope of practice, but the formal designation is "practitioner/clinician."

Members of the Joint Practice Commission and others involved are enthusiastic about the future of joint practice arrangements. They see them as growing in numbers and also in scope of practice. And, no one believes this more fervently than the chairperson of the Michigan Joint Practice Commission, Brigid Warren, assistant professor of nursing at Michigan State University, under whose leadership much progress is being made toward making joint practice the trend of the future.

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cally a well-baby practice. She provides counseling on community child health problems, and diagnoses and treats common acute problems such as poison ivy and streptococcal sore throat, using appropriate written guidelines.

The other nurse practitioner, Helena Cook, is trained for ob/gyn practice. She handles routine visits of pregnant women, conducts ultrasound tests, takes Pap smears, does breast and pelvic exams, fits diaphragms and provides contraceptive advice.

For these services, the nurse practitioners are paid commensurate with their training and their roles.

"Most patients not only accept but like seeing the nurse practitioners because they are specifically trained to counsel and educate and because they are able to give extra time to their patients," says Doctor Creighton, who began her career as a nurse.

MDs', nurses' protocols

The respective protocols followed by nurses and doctors are spelled out in writing, a practice recommended by the Michigan Joint Practice Commission.

In the Health Maintenance Organization (HMO) where Doctor Henderson practices, masters degree-prepared clinical nurse specialists work collaboratively and interdependently with physicians. The clinical nurse specialists perform histories and physicals, manage chronic disease, assess common acute illnesses and counsel and educate patients.

The same HMO also has baccalaureate degree nurses who carry out a variety of responsibilities, such as health assessments and patient education and develop patient-education materials. They also do phone triage and manage common medical problems by protocol.

Not all nurse clinicians work in group practices. Louis Zako, MD, chairman of the MSMS Council, and his wife, Mary, operate a nationally-known joint practice in their Dearborn Heights office.

Doctor Zako, like other physicians who have tried joint practice, stresses the point that doctors do not have to see every patient who comes to the office and often should not see some patients.

"Nurses as a group are better trained to do education and counseling than doctors and they can give more time to the patient. It is not that the nurse is less well trained than the doctor; it is that the nurse is trained differently."

"Some say she is more thorough and more gentle," he says.

But can a solo physician generate enough work to keep a nurse clinician busy full time? Doctors Creighton and Zako believe that with greater patient acceptance of nurse practitioners, the economic feasibility of joint practice becomes more favorable.

AMA-ERF helped 4,000 students in 1978 studies

In 1978, more than 4,000 medical students and young physicians-in-training borrowed $5.8 million to help meet their expenses through the American Medical Association Education and Research Foundation Student Loan Guarantee Program.

AMA Executive Vice President James H. Sammons, MD reports also that a total of $1,336,383 was channelled directly to the nation's medical schools in grants from AMA-ERF distributed in March, 1979.

In the Student Loan Guarantee Program, AMA-ERF deposits funds with banks to guarantee the loans, in effect co-signing the note with the student, Doctor Sammons pointed out. Since the program was established in 1962, more than $90 million in loans have been arranged and guaranteed by the AMA-ERF.

Some 94 percent of all borrowers whose loans have matured since 1962 have repaid or are repaying their obligations with no special prompting, the AMA executive said.

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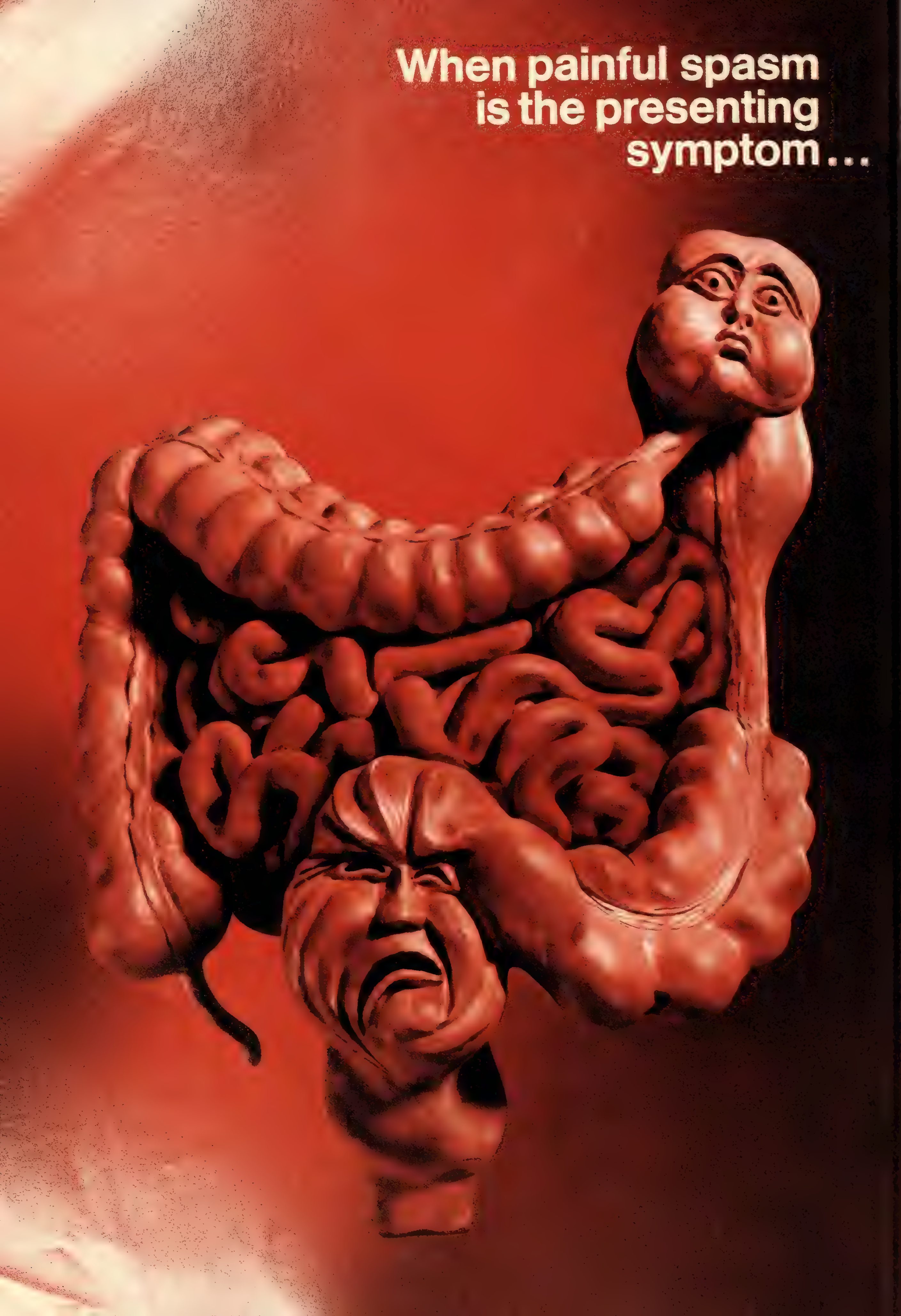
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..in the functional bowel/irritable bowel syndrome*

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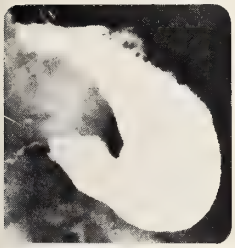
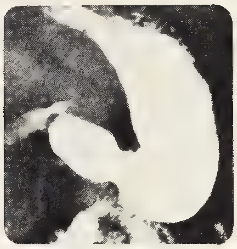
. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

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Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS
For use in the treatment of infant colic (syrup)
Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition
Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis; cycloplegia, increased ocular tension; loss of taste; headache; nervousness, drowsiness; weakness, dizziness; insomnia, nausea; vomiting, impotence; suppression of lactation; constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION. Dosage must be adjusted to individual patient's needs
Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults*. 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water) Bentyl 20 mg.: *Adults* 1 tablet three or four times daily Bentyl Injection: *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used
Product Information as of October. 1978

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Quality of training program reason residents locate

Why do young physicians choose certain hospitals and institutions for their residency training programs?

"The quality of the training program and the teachers" was the reason given most often in a study of 50 replies received by the Michigan Health Council from young house officers.

When asked "What were the most influential factors that encouraged you to select your residency program?" there were many different replies.

Program quality

Comments by the largest number all focused on the quality of the program. A family physician at Southfield Providence Hospital wrote "quality of the medical education offered," and an orthopedic surgeon in the Bronson-Borgess program in Kalamazoo said "quality of the house officers."

A young surgical intern at Royal Oak Beaumont Hospital replied, "the attending physicians are outstanding," and an internist in training at the University of Michigan was pleased with the "academic strength" of the program.

A young man in the family practice program in Saginaw said he was influenced by the "excellent residents and good director," and a pediatric resident at the University Hospital said the "interview made a good impression — high quality program."

The study was conducted by Herbert A. Auer, executive vice president of the Michigan Health Council, which conducts the Physician Placement Service for the state.

The responses about the quality program far outnumbered any other grouping of replies.

Patient variety

The second common reason dealt with the "variety of patients" that the physician would encounter. A family practice resident at Bon Secours Hospital in Grosse Pointe liked the "availability of exposure to many patient problems" while a family practice resident in the WSU program was impressed with the "variety of conditions" he would treat.

Because many medical students are married, the concerns of the spouse were a factor in the residency-selection process. One man was in the family practice program in the Detroit area because "my wife attends law school here." A graduate of one of the Michigan schools returned a questionnaire from Minneapolis and commented, "my wife wanted to come to the Twin Cities and I too felt the area was attractive." Another Michigan graduate wrote from Omaha and reported he was there in pediatric residency primarily because "my wife has started a physician's assistant program here."

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News

By Katie Brewbaker, MSMS staff

A special reception was held at the Community Arts Auditorium at Wayne State University for retiring faculty and staff and to recognize those whose careers at WSU span many years. Among the retirees honored was **Paul V. Woolley, MD,** who has been on the faculty of the School of Medicine for more than 25 years. Recipient of a 40-Year Award was **I. Muir Clapper, MD,** also on the medical school faculty.

The Notre Dame Club of Jackson has presented its University of Notre Dame Award of the Year to **George H. Phillips, MD,** for his contributions to medicine and involvement with the Jackson Symphony Orchestra, as first violinist and vice chairman of the symphony association.

A former Saginaw pathologist is author of a full-page story in a recent issue of *AMA News* on the Turin Shroud of Christ. **Robert Bucklin, MD,** now of Houston, Texas, has studied the Shroud for many years.

Named chief of the newly created Division of Radiation Biology at Henry Ford Hospital is **Haim I. Bicher, MD.** This division of the Department of Therapeutic Radiology will research the effects of radiation on biological materials and introduce the latest developments in cancer treatment.

Two recipients of 50-Year Awards at the recent MSMS House of Delegates also were honored by their respective medical schools. **Paul E. Medema, MD,** was recognized by the University of Marquette Medical School and **Emil Shebesta, MD,** by his alma mater, the University of Wisconsin Medical School. Both physicians are from Muskegon.

Michigan physicians continue to be elected in impressive numbers to the presidencies of national medical organizations. **Giles G. Bole, Jr., MD,** Ann Arbor, has been voted president-elect of the American Rheumatism Section of the Arthritis Foundation; **Mohammad N. Akhter, MD,** Lansing, will assume the presidency of the American College of International Physicians, Inc., in September; **Francis L. Purcell, MD,** Ann Arbor, is the new president-elect of the American Occupational Medical Association, and **John R. Thornbury, MD,** Ann Arbor, has been named president-elect of the National Association of University Radiologists.

Doctor Bole

Doctor Akhter

Doctor Purcell

The late **Ethelene J. Crockett, MD,** will be posthumously honored by the Michigan Cancer Foundation for her service on the boards of the Michigan Cancer Foundation, United Community Services, and the Health Care Planning Council in recognition of the time and talent she gave to the prevention and treatment of cancer.

The National Endowment for the Humanities will fund awards to two MSU College of Human Medicine faculty members to participate in 1979 summer humanities seminars for medical and health care teachers. **Arthur R. Kohrman, MD,** will study the philosophical roots of bioethics at the Georgetown University Center for Bioethics, and **Margaret Z. Jones, MD,** will join a University of Virginia seminar to study the broad humanistic perspective of today's dilemmas in health care.

After the rigors of medical school, what is uppermost in the mind of the new doctor? Setting up a practice, of course. But then what? Well, if you are **Jonathan Licht, MD** or **Jim Barahal, MD,** it's off to the Comedy Factory in Ferndale, or the Comedy Castle in Walled Lake, on your night off to spend 15 magical minutes as a stand-up comic!

John E. Manning, MD, Saginaw, was honored by the Saginaw Club at a special dinner for his contributions to the surgical residency training program of the Saginaw Cooperative Hospitals, Inc. The annual medical research and literature review competition for the residency staff also will be named after him.

New chairman of the department of radiology at the University of Michigan Medical School is **Douglass F. Adams, MD,** former director of cardiovascular radiology at Peter Bent Brigham Hospital, in Boston. Doctor Adams fills the vacancy created when **Walter M. Whitehouse, MD,** relinquished the chairmanship to return to a full-time role as clinician and professor.

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In this age of double-digit inflation, it is truly remarkable to find a product whose price is falling. This 5% MPMLC rate decrease follows a 2.2% decrease which took effect January 1, 1978.

Despite inflation, MPMLC has not once increased rates since it began writing insurance three years ago.

Congratulations to the Michigan physicians who had the foresight to establish their own insurance company — who chose not to rely upon a temporary governmental remedy to the medical malpractice problem.

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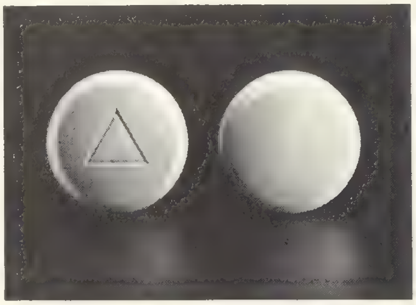
The Make

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

**FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were
not bioequivalent to a
reference product. As y
know, there is substan
literature on this subje
affecting many drugs, i
cluding such antibioti
as tetracycline and ery
thromycin. The record
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products. Research-
intensive companies
have far better records
than those that do no r
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*MYTH: Industry favors
only "expensive" brand
names and denigrates a
generics.*

**FACT: PMA companie
make 90 to 95 percent
the drug supply, inclu
ing, therefore, most of
generics. Drug nomen
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Matters.

TH: Generic options al-
st always exist.

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:T: Market data show
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ggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

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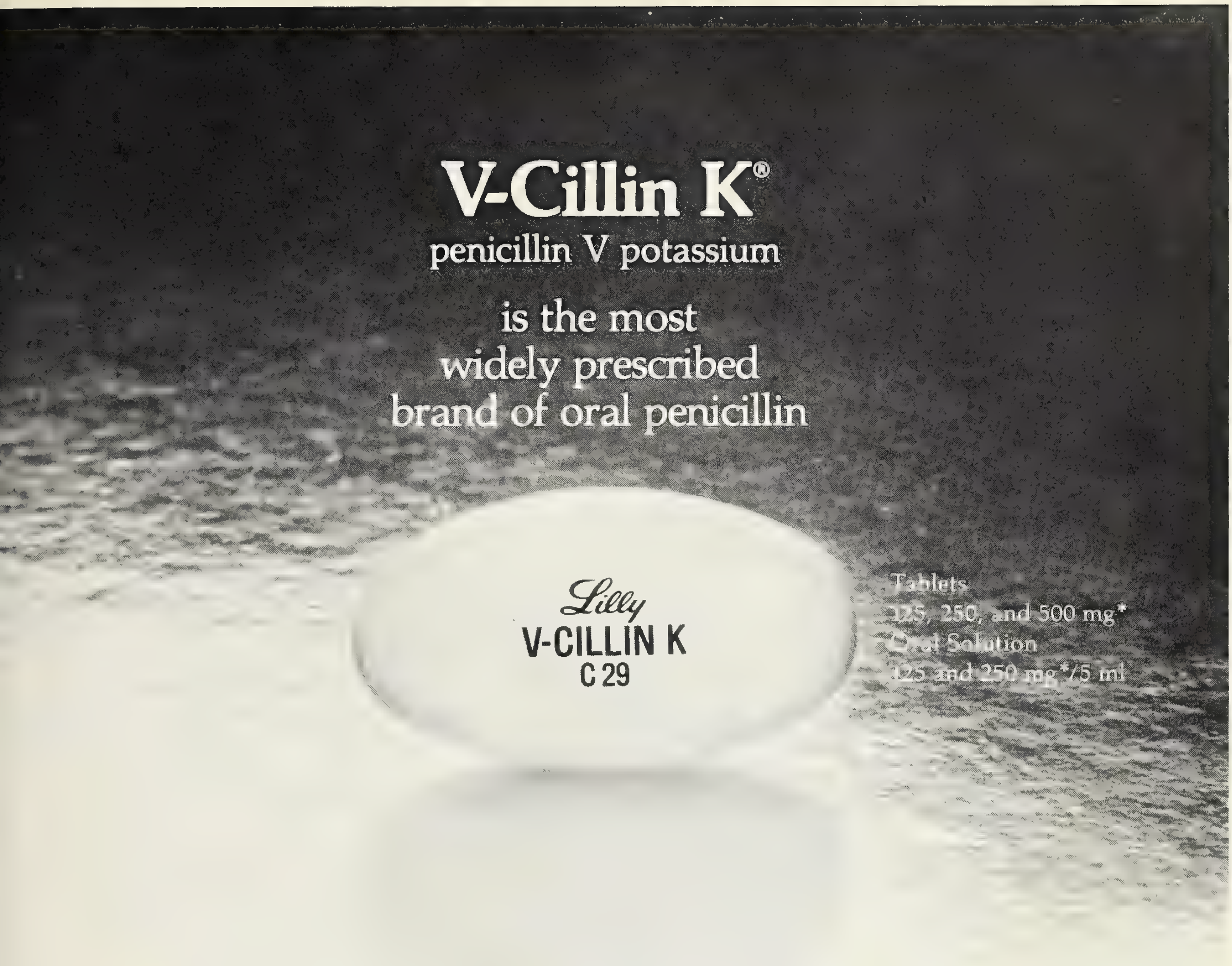
(Continued on page 456)



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Deaths

Robert L. Atkinson, MD
St. Joseph

Robert L. Atkinson, MD, of St. Joseph died May 16 at the age of 62. A retired urologist, Doctor Atkinson graduated from the University of Illinois. Doctor Atkinson practiced for eight years in Bloomington, Illinois and also in Cleveland before opening practice in St. Joseph in 1960. He was a member of the Chicago and American urological societies, and was a fellow in the American College of Surgeons. He was certified by the American Board of Urology.

Bert M. Bullington, MD
Saginaw

Bert M. Bullington, MD, Saginaw died May 12 at the age of 68. A heart specialist, Doctor Bullington received his medical degree from Washington University, St. Louis, MO. After serving as chief of medicine at U.S. Army Hospital in France during WW II, he established his practice in internal medicine in Saginaw in 1946. He became chief of internal medicine at Saginaw General and director of the coronary care unit at St. Luke's Hospital. In 1969 Doctor Bullington was named a clinical professor of medicine at Michigan State University and in 1973 MSU honored him for his teaching in the College of Human Medicine. He was a former president of the Saginaw County Medical Society, vice president of Saginaw General Hospital's medical staff, a trustee of the American Society of Internal Medicine, a trustee of the Michigan Heart Association, and a fellow of the American College of Physicians.

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Joel D. Gottlieb, MD
Ann Arbor

Joel D. Gottlieb, MD, Ann Arbor, died May 29. He was 42. Dr. Gottlieb received his MD degree from the University of Michigan in 1961. He was an intern and resident in anesthesiology at the University of Michigan Medical Center and in 1967 became a diplomate of the American Board of Anesthesiology. Doctor Gottlieb was on the staff of Harper Hospital and at the time of his death vice chairperson of the board of directors of the Ann Arbor Chapter of the American Civil Liberties Union.

Murray W. Hess, MD
West Bloomfield

Murray W. Hess, MD, West Bloomfield, died June 16. He was 57. Doctor Hess was in charge of industrial health at the Henry Ford Hospital outpatient center in West Bloomfield. He received his MD degree from Wayne State University School of Medicine. He was a fellow of the Michigan Academy of Physicians and a member of the American College of Emergency Physicians.

Russell J. Himmelberger, MD
Lansing

Russell J. Himmelberger, MD, Lansing, died June 5 at the age of 77. Doctor Himmelberger was a graduate of the University of Michigan Medical School. Until his retirement in 1969 he was affiliated with Edward W. Sparrow and St. Lawrence Hospitals. He was a past president and secretary of the Ingham County Medical Society and served in the Army Medical Corps in England during World War II.

Roy C. Kingswood, MD
Grosse Pointe Park

Roy C. Kingswood, MD, of Grosse Pointe Park, died in Hutzel Hospital May 24. He was the retired medical director of Ex-Cello-O Corporation and a member of the American, Michigan and Wayne County Medical societies. Doctor Kingswood was 85.

Earnest O. Singleton, MD
Detroit

Earnest O. Singleton, MD, 32, died unexpectedly at his home in Detroit May 6. Doctor Singleton, an orthopedic surgeon, graduated from Wayne State University in 1973, serving his residency at Harper-Grace Hospital before opening private practice in August. Doctor Singleton was co-founder and first president of the Black Medical Students Association at WSU. He won the Michigan Heart Association's Outstanding Achievement Award and an award for research in hereditary diseases — both in his second year of medical school.

William F. Wangner, MD
Royal Oak

William F. Wangner, MD, a specialist in radiology, died May 10. He was 67 and a resident of Royal Oak. Doctor Wangner received his degree in medicine from the University of Michigan in 1935 and practiced at Jennings Memorial Hospital and Lapeer County General Hospital.

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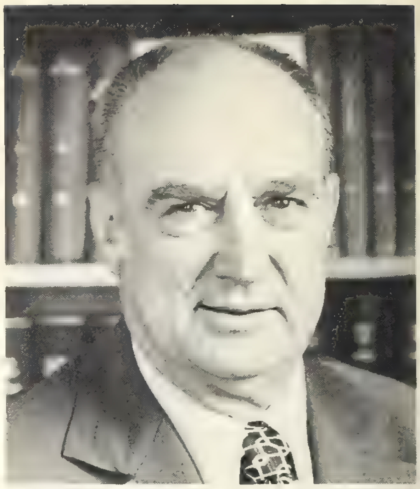
Physicians should examine selves for ways to cut medical costs



Ernest P. Griffin, Jr., MD
MSMS President

As you will recall, we have been laying out a program for medical cost containment with recent President's Page articles. These articles are excerpted from my address to the 1979 MSMS House of Delegates.

Last month I described ways in which the general public can achieve cost containment. This month I'll suggest physicians' contributions.

We physicians have made nearly all of the advances in the practice of medicine. Yet, today we are jeopardizing all of this by some of the things we are doing. And I submit to you that we will receive no aid from anyone until we clean up our own house.

Our guilt shows in many ways. Just for starters, let us consider a few things we are doing and a few things we are not doing.

1. We have made only small efforts to police ourselves.

2. We have made no effort to limit access to the system to those who really need it.

3. We have made no effort to publicize the knowledge that we have.

4. We have made no real effort to control the cost of medical care after the patient has gained access to the system.

To elaborate on these points:

Policing ourselves

Let me suggest that a number of things should be critically examined:

- The referral of patients to captive laboratories in which the physician has an ownership interest.

- Routine tests and routine testing procedures. Why should routine orders on admission be allowed? Why should physicians have to suffer the indignity of a letter from Blue Cross/Blue Shield of Michigan that states, "The burden of proof for the medical indication for diagnostic laboratory tests rests on the physician who orders it?" This was part of our basic medical education. Actually, it is only because we do not attempt to individualize and order only indicated tests. The control of routine testing procedures in the hospital setting is a step in the right direction, but control in an office setting with a captive laboratory is another thing.

- Self-referral. The use of modalities in which the physician has no expertise.

- The ordering of tests for which there is no medical indication. This is usually explained as defensive activity. I can tell you that, in most cases, a physician is sued for what he does, and not for failing to order a test. A lack of a test result is not the critical issue unless a normal prudent physician would have considered it essential to the diagnosis.

- Injudicious use of physician's assistants. The unsupervised use of physician's assistants in an office and in satellite installations must be eradicated.

- The assumption that no physician can be in error. Our refusal to indulge in a controlled second opinion program has certainly not endeared us to anybody.

- Spending our time examining the wrong patient. As an example, cancer of the colon is a surgically-curable disease at the proper stage of its development. Yet, in this country, the death rate remains the same. Routine barium enema on every individual in this country is an impossibility. However, the examination of all persons with positive chemical tests for blood while on a meat-free diet will get us these patients at a more opportune time.

The emergency room generates many costs by its improper utilization. Physicians, the public, employers and third party payors must accept that the word "emergency" is exactly that. The use of these facilities for general diagnostic work must be stopped.

Publicizing our knowledge

It requires only superficial consideration to realize what dissemination of our knowledge in this area could do. Our state chronic institutions are filled with individuals who are there through no fault of their own. Genetic and chromosomal studies and transmissable disease studies have shown where the risks are. If the public was educated in these areas, many would elect not to populate the world with these unfortunate victims. This knowledge should be made available to every physician in order that he may properly counsel his patients.

Next time: Controlling costs in hospitals after access to the medical system has been gained.

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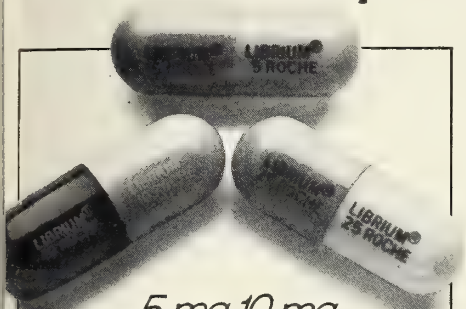

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram

VOL. 78, NO. 24 AUGUST 24, 1979

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information is avail-
from the Medical Re-
Program, Center for
th Sciences, Oakland
ersity, Rochester,
3 (313) 377-3563.

MSMS asks for clearer wording of FTC complaint against MSMS

MSMS legal counsel on Aug. 13 filed a motion with the Federal Trade Commission asking for clearer language in two portions of the FTC Complaint against MSMS filed July 27. The motion asks "for a more definite statement as to the allegations set forth...for the reason that...respondent (MSMS) is unable to plead responsively in the required manner..." One of the objectionable paragraphs tries to detail MSMS purposes and the other alleges that MSMS has restrained competition among Michigan physicians. Full text of the Complaint is printed in the August 10 Medigram.

New Medicaid accounting system subject for MSMS study

The chairman of the MSMS Medicaid Liaison Committee is meeting with the state's executive officers to better understand the details of a state move to accrual accounting methods for the Medicaid program. David Siegel, MD, Lansing, committee chairman, also plans informational meetings with key legislators when they return for their fall session in September. The state's plans to change to the accrual accounting system for Medicaid have generated some confusion regarding whether funds appropriated for the 1979-80 Medicaid budget will be sufficient to meet actual expenses. The bulk of the Medicaid Liaison Committee's most recent meeting August 9 was taken up with study of the new accounting system.

Watch for coming *Michigan Medicine*

Some interested Michigan physicians' views of what should be done to help impaired physicians will be published in the September issue of Michigan Medicine, coming out soon.

CAPSULES CONTINUED

FOLLOWING ITS OWN TIMETABLE, the Blue Cross/Blue Shield of Michigan Board's Health Care Cost Committee is unilaterally directing inauguration of its new cost containment reimbursement plan for physicians. The plan was approved July 22 by the Blues board. MSMS understands that the new Blues system seeks to control costs by limiting the number of physician services delivered. A certain amount will be allocated to cover a particular service for a time period and once it is paid out, no more will be available, regardless of how many more such services might be provided by physicians. The Blues' cost containment plan is to be fully operational by June 30, 1980, following a four-step phase-in process.

DETROIT-AREA MSMS MEMBERS should plan to watch WXYZ-TV, Channel 7 at 7:30 p.m. on Labor Day, Sept. 3, when the station airs a mini-documentary on "The Impaired Physician." Reporter Liz Twardon worked closely with MSMS staff and the Committee on Impaired Physicians in preparing the special report.

MSMS Judicial Commission to study AG's new lab ruling

On Sept. 5, the MSMS Judicial Commission will review for information the attorney general's recent opinion on physician ownership of laboratories. The AG has ruled that the new public health code prohibits a physician directing a patient to use the services of a laboratory in which the physician has a financial interest. The AG further ruled the physician is not free of violating the code by telling the patient of his or her interest in the lab.

MSMS legal counsel says this opinion is not necessarily the final word. MSMS understands the public health code provision is being challenged in at least two court actions in Oakland and Genesee counties.

In April, 1977, the MSMS Judicial Commission opined that physicians may share ownership in a laboratory as long as the patients are not exploited.

Registration forms coming soon for MSMS Annual Scientific Meeting

MSMS members may begin registration for the 1979 MSMS Annual Scientific Meeting Nov. 13-14-15 with the arrival of the first September *Medigram* and September *Michigan Medicine*. Both will contain registration forms for all 57 half-day courses, as well as the two-day Advanced Cardiac Life Support course. Annual Scientific Meeting Chairman Samuel M. McMahon, MD, advises physicians to register early, as classes will begin to fill soon, and enrollment in some is limited. Those who make early hotel reservations also will benefit by being able to take advantage of reduced rates.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

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Editor: Judith Marr

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Here is your program, Doctor, for the . . . 1979 MSMS Annual Scientific Meeting Nov. 13-14-15 at Hyatt Regency Dearborn . . .

SEP 26 1979

Registration form appears on page 19

Michigan Medicine

Medigram

VOL. 78, NO. 25 SEPTEMBER 7, 1979

Here it is, Doctor — your personal advance copy of the full program for the 1979 MSMS Annual Scientific Meeting Nov. 13-14-15 at the Hyatt Regency Dearborn.

This *Medigram* will provide you with all the information needed to register for the courses you want to attend.

"Advance registration is important to ensure a place in the courses of your choice," says Samuel M. McMahon, MD, Lansing, Annual Scientific Meeting chairman. Several of the courses have limited enrollments.

In this *Medigram* you'll find course topics, outlines, times, directors, faculty members and their academic titles.

You'll also find a list of special activities planned during the three-day event by specialty societies, the registration form for the entire Annual Scientific Meeting, and a special article about the two-day Advanced Cardiac Life Support course planned during the meeting.

"I think this year's courses will be outstanding in many respects," says Doctor McMahon. "They will be realistic and helpful and are planned to provide a good educational update and summary of the subjects chosen."

56 half-day courses

Doctor McMahon and his advisory committee have been working for a year now with Michigan specialty society and medical school leaders to plan an exciting, balanced program of half-day courses.

Virtually every major specialty society has helped plan courses. Faculty will come from several states to provide the latest knowledge in their respective areas.

The 56 half-day courses will offer three Category I credit hours each. A total of 18 credits may be earned by the physician attending the entire three-day meeting. The two-day Advanced Cardiac Life Support course will award 16 credit hours and certification as providers in ACLS by the Michigan Heart Association, for those candidates who successfully complete the testing according to American Heart Association standards.

Doctor McMahon, his committee and the CME Programming Committee, headed by Carl F. Hammerstrom, MD, have planned some major innovations for this year's Annual Scientific Meeting.

They include "alpha-omega" sessions and "wet clinics."

"The meeting this year will differ from previous years in that there will be a greater emphasis on a 'hands-on' and participatory experience," explains Doctor McMahon of the wet clinic approach.

Alpha-omega sessions will examine disease entities as they affect the patient of all ages — from birth to death.

"As in previous years, most programs will be planned with the family practitioner and ambulatory care specialist in mind," says Doctor McMahon. All but one of the 57 courses also will carry AAFP prescribed credit.

A renovated, expanded Hyatt Regency Hotel will provide the setting. Spouses accompanying physicians attending the three-day session should find many activities to fill their time in the Hyatt and in the surrounding metropolitan area.

Dearborn itself is home to the Greenfield Village/Henry Ford Museum complex, and the Hyatt is connected by its unique "people-mover" on its elevated guideway to the Fairlane Town Center.

Reservation form inside

Page 19 of this issue contains the registration form, which must be completed and sent with check.

Room reservations are to be made direct by the physician with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, 48126. "Early reservations will allow the physician to take advantage of a discount offered by the Hyatt," says Doctor McMahon.

The Hyatt will provide a luncheon each noon in the MSMS exhibition hall. The registration form asks physicians to indicate which days they would like to take advantage of this special arrangement.

Again this year, the tuition of $4 per credit hour for MSMS members and $8 per credit hour for nonmembers will help cover the MSMS expenses for the Scientific Meeting. Residents and interns will be permitted to register in advance without charge.

Any physicians with questions may telephone MSMS at 517/337-1351 and ask for Sherry Fent.

Complete and return registration form on page 19

36 COURSES OFFER 3 HOURS EACH OF CATEGORY I CREDIT

Courses Tuesday morning, Nov. 13

ALL COURSES RUN FROM 8:30 TO NOON WITH HALF-HOUR BREAK

☐ Alpha-Omega Session: Overview of Pulmonary Diseases in Children, Adults and Elderly Patients

PRESENTED BY: Michigan State University College of Human Medicine and Ingham Medical Center

This course will focus on the characteristic diseases of the respiratory system during human development. Diagnostic procedures and treatment plans will be reviewed for the common respiratory diseases of childhood, adulthood, and the geriatric age group. Our emphasis will be upon recognition and treatment of the illnesses which are likely to be seen frequently by a family practitioner. Time will be provided at the end of each presentation for questions and discussion.

COURSE DIRECTOR: Samuel M. McMahon, MD, Lansing

PRESIDING: Doctor McMahon

SPEAKERS/SUBJECTS:

Samuel M. McMahon, MD, Associate Professor, Michigan State University College of Human Medicine and Ingham Medical Center, Lansing
"Adult and Occupational Pulmonary Diseases"

George Polgar, MD, Director of Respiratory Disease Division, Childrens Hospital of Michigan; Professor of Pediatrics and Medicine, Wayne State University School of Medicine
"Most Frequent 'Age-Related' Respiratory Diseases of Childhood"

Robert Klimek, MD, Assistant Professor, Michigan State University College of Human Medicine and Ingham Medical Center, Lansing.
"Diseases of the Aging Lung"

☐ Cancer Prevention: Practical Medicine for the Family Physician

PRESENTED BY: Michigan Cancer Foundation

A schedule of recommended cancer surveillance examinations and reexaminations for identifiable sets of patients will be described. Risk factor analysis and cost-effectiveness optimizations based on the known quantitative characteristics of major cancers will be presented along with results. The purpose of the session is to give physicians a practical, economical and scientifically sound regimen to use in providing protection against cancer to their patients.

COURSE DIRECTOR: Michael J. Brennan, MD, Detroit

PRESIDING: Doctor Brennan

SPEAKERS:

Michael J. Brennan, MD, Michigan Cancer Foundation, Detroit
John Burrows, MD, Medical Oncologist, St. John Hospital, Detroit
Herbert Bloom, DDS, PhD, Board of Directors, Michigan Cancer Foundation and Continuing Medical Education, Sinai Hospital of Detroit
John R. F. Ingall, MD, Clinical Associate Professor of Surgery, Wayne State University School of Medicine

☐ Diabetes — The State of the Art (Part I)

PRESENTED BY: MSMS Section on Clinical Pharmacology

This first of a two-part session will be aimed toward prima care physicians who manage the uncomplicated diabetic. this segment, discussion will cover what is diabetes (ADA n classification), dietary therapy, insulin therapy, oral drugs use and misuse, and common diabetic complications. Parti pants may want to continue on and enroll in the second sessi which will deal with specific complications of diabetes.

COURSE DIRECTOR: George L. Royer, Jr., MD, Manager Medical Pharmacology, The Upjohn Company, Kalamazoo

PRESIDING: Doctor Royer

SPEAKERS/SUBJECTS:

Rebecca M. Norris, MD, The Upjohn Company, Kalamazoo
"What is Diabetes?"

Karl E. Sussman, MD, Associate Professor of Medicine, Univ sity of Colorado School of Medicine, Denver
"The Role of Dietary Therapy in Diabetes Mellitus"

John Galloway, MD, Eli Lilly & Company, Senior Clini Pharmacologist, Clinical Research Division, Indianapolis
"Insulin Use in Diabetes Mellitus"

Manuel Tzgournis, MD, Professor of Medicine, Division of docrinology and Metabolism, Ohio State University Medi School
"Oral Drugs — Use and Misuse"

A. M. Lawrence, MD, U. S. Veterans Administration, Edw Hines, Jr. Hospital, Hines, Illinois
"Common Diabetic Complications"

☐ Hematology for Non-Hematologists

PRESENTED BY: Wayne State University School of Medicin

This course will focus on three main topics in the area hematology. One discussion will deal with the patient wit bleeding disorder and will include sample cases. A seco topic will emphasize the workup of patients with lymphoma. third topic for discussion will deal with macrocytic anemi There will be time for questions and answers after each prese tation.

COURSE DIRECTOR: Carter R. Bishop, MD, Detroit

PRESIDING: Doctor Bishop

SPEAKERS/SUBJECTS:

Liborio Tranchida, MD, Associate Professor of Medici Wayne State University School of Medicine and Harper Hos tal, Detroit
"Patient with Bleeding Disorders"

Freeman M. Wilner, MD, Clinical Associate Professor Medicine, Wayne State University School of Medicine a Beaumont Hospital, Royal Oak
"Workup of Patients with Lymphoma"

Carter R. Bishop, MD, Professor of Medicine, Wayne State U versity School of Medicine and Detroit General Hospital
"Macrocytic Anemias"

☐ Industrial, Environmental Pollutants

PRESENTED BY: Michigan Occupational Medical Association

This course will describe to physicians some of the health dangers that are encountered in industry. It is also to give them a better insight into industrial health problems and what we are doing in the way of health management to correct these problems. The speakers will relate some of the problems related to lead, arsenic and other similar substances. The program will portray the various methods used to educate and protect the employee in the industrial environment. From the knowledge that these presentations impart, it is hoped that we can create a better liaison between the personal physician and the industrial physician so that the health of our employees, their patients, can be better served.

COURSE DIRECTOR: Denis F. Cash, MD, GM Parts Division, Flint

PRESIDING: Doctor Cash

SPEAKERS/SUBJECTS:

David C. Laderach, MD, Associate Medical Director, Ford Motor Company, and Medical Director, Ford Aerospace and Communications Corporation, Detroit
"Future Directions for Occupational Health: Regulations and Education"

everly G. Ware, DPH, Corporate Health Education Programs Coordinator, Ford Motor Company, Detroit
"Future Directions for Occupational Health: Regulations and Education"

aroslav J. Vostal, MD, PhD, Head, Bio-Medical Science De- artment, GM Research Laboratories, GM Technical Center, Warren
"Health Effects Research in Diesel Emissions"

☐ New Concepts in Evaluation and Treatment of Stroke Syndrome (Wet Clinic)

RESENTED BY: Department of Neurological Surgery, Henry ord Hospital

his course will provide a review for all physicians of the new dvances in stroke. Twenty-minute lectures will be presented n the differential diagnosis of stroke in the community hospi- l, non-invasive diagnosis of stroke, what tests can reveal, and hen to use aspirin, anticoagulants and surgery. Forty minutes ill be allowed for a wet clinic and discussion. At the comple- on of this course the physician should understand that stroke not a diagnosis, but a manifestation of disease, that he can tively participate in the differential diagnosis of stroke, and at much can be done to benefit the stroke patient.

OURSE DIRECTOR: James I. Ausman, MD, PhD, Detroit

RESIDING: Doctor Ausman

EAKERS/SUBJECTS:

mes I. Ausman, MD, PhD, Chairman, Department of Neuro- gical Surgery and Neurology, Henry Ford Hospital, Detroit
"Differential Diagnosis of Stroke in the Community Hospital"
"New Approaches in the Treatment of Stroke"

cob L. Chason, MD, Neuropathologist, Henry Ford Hospital, troit
"Pathology of Stroke"

thony Furlan, MD, Department of Neurology, The Cleveland inic, Cleveland
'Non-Invasive Tests in the Diagnosis of Stroke"
"Vertebral Basilar Insufficiency — Diagnosis and Management"

Roushdy S. Boulos, MD, Division Head, Diagnostic Radiology, Henry Ford Hospital, Detroit
"Invasive Tests in the Diagnosis of Stroke — Brain Scan, CT Scan, Angiogram"

☐ Preventing Physician Suicide Through Early Recognition and Proper Care

PRESENTED BY: MSMS Committee to Assist Impaired Physicians and Michigan Psychiatric Society Committee on the Well-Being of Physicians

This course intends to provide the basic criteria of the presuicidal state as it presents in the physician who may be afflicted, as well as a discussion of the common individual and family dynamics which may lead up to this state. Factors aiding recognition and intervention will be enumerated and discussed. Issues will be discussed regarding improved training and other preparation of physicians in the event that they may become candidates for professional help with emotional problems at some time in their professional lives. The responsibility of organized medicine toward members vulnerable to suicide will be emphasized, as well as the duty this recognition imposes on all individual physicians. The role of the spouse will be discussed and they are extended a speceial invitation to attend and participate.

COURSE DIRECTOR: Douglas A. Sargent, MD, Grosse Pointe

PRESIDING: Doctor Sargent

SPEAKERS/SUBJECTS:

Thomas E. Bittker, MD, Director of Health Maintenance Services, Arizona Health Plan and Chairman, Division of Psychiatric Education, Phoenix
"Preventing Physician Suicide"

Douglas A. Sargent, MD, President, Michigan Psychiatric Society; Clinical Associate Professor of Psychiatry and Adjunct Professor of Law, Wayne State University
"The Family Context of Physician Suicide"

☐ What's New in Office Gynecology

PRESENTED BY: Department of Obstetrics/Gynecology, William Beaumont Hospital

This course will give practicing physicians an overview of the basic oncology, pelvic infections and gynecologic endocrinology needed in office gynecology. A panel discussion will follow each of the three primary presentations.

COURSE DIRECTOR: R. Ralph Margulis, MD, Royal Oak

PRESIDING: Doctor Margulis

SPEAKERS/SUBJECTS:

Alfred I. Sherman, MD, Director, Gynecology/Oncology, William Beaumont Hospital, Royal Oak; Professor, Gynecology and Obstetrics, Wayne State University School of Medicine and Director, Research and Education of Obstetrics/Gynecology, Sinai Hospital, Detroit
"Oncology"

S. Leonard Cohn, MD, Adjunct Instructor, Oncology/Obstetrics, Wayne State University School of Medicine, and Senior Attending Staff, William Beaumont Hospital, Royal Oak
"Pelvic Infections"

R. Ralph Margulis, MD, Associate Medical Director for Clinical Affairs, William Beaumont Hospital, Royal Oak; and Associate Professor, Department of Gynecology and Obstetrics, Wayne State University School of Medicine
"Gynecologic Endocrinology"

Courses Tuesday afternoon, Nov. 13

ALL COURSES RUN FROM 1:30 TO 5:00 P.M. WITH HALF-HOUR BREAK

☐ Alpha-Omega Session: Birth and Death of the Endocrine System

PRESENTED BY: Michigan State University College of Human Medicine

This course will provide practical information about the physiological processes through which the endocrine system passes in embryogenesis, childhood, adolescence, maturity, and old age. The impact of these changes upon patients will be discussed as well as the interrelationship between disease processes and endocrine function. The effects of age upon the "normal" values for various endocrine testing procedures will be fully presented.

COURSE DIRECTOR: David R. Rovner, MD, East Lansing

PRESIDING: Doctor Rovner

SPEAKERS/SUBJECTS:

Arthur F. Kohrman, MD, Associate Dean for Educational Programs, Michigan State University College of Human Medicine
"The Endocrine System in the Young Years"

David R. Rovner, MD, Professor of Medicine, Department of Medicine, Michigan State University College of Human Medicine
"Maturity and the Endocrine System"

Robert I. Gregerman, MD, Gerontology Research Center, National Institutes of Health, Baltimore City Hospitals, Baltimore
"Relationship Between Aging and Changes in Function of the Endocrine System"

☐ Basic Life Support

PRESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course is being offered for those physicians who are not currently certified in basic life support and who may wish to continue on in the advanced cardiac life support courses. It will consist of basic lectures, including management of the airway and cardiac massage. Time will be provided for a practice session on the manikins.

CO-COURSE DIRECTORS: Ann L. Harwood, MD, Butterworth Hospital, Grand Rapids, and **Eugene C. Grochowski, MD, PhD,** Clinical Faculty, Southwestern Michigan Area Health Education Center, Kalamazoo.

☐ Common Errors in ECG Interpretation (Wet Clinic)

PRESENTED BY: Department of Medicine, Wayne State University School of Medicine

Through audience participation in the interpretation of sample ECG's, this course will amplify and explain common errors in general physician ECG interpretation. Special emphasis will be placed on diagnosis of dysrhythmias and acute myocardial infarction and assessment of pacemaker function.

COURSE DIRECTOR: Franklin E. Hull, MD, Detroit

PRESIDING: Doctor Hull

SPEAKERS:

Frederick N. Talmers, MD, Professor of Medicine, Wayne State University School of Medicine

Franklin E. Hull, MD, Associate Professor of Internal Medicine, Wayne State University School of Medicine

☐ Diabetes — The State of the Art (Part II)

PRESENTED BY: MSMS Section on Clinical Pharmacology

This second of a two-part session will be designed fo specialists or primary care physicians who take care of problem diabetic cases and their specific complications, such as vascular disease and diabetic coma. It will also discuss new developments such as hemoglobin, A_1C, insulin receptors and transplantation. It is suggested that participants who have no had previous study in specific complications of diabetes enrol in the morning session on diabetes offered prior to this one.

COURSE DIRECTOR: George L. Royer, Jr., MD, Manager o Medical Pharmacology, The Upjohn Company, Kalamazoo

PRESIDING: Doctor Royer

SPEAKERS/SUBJECTS:

Charles Shuman, MD, Professor of Medicine, Temple University School of Medicine, Philadelphia
"Diabetic Coma"

Jean Partamian, MD, Staff Physician, Division of Metaboli Diseases, Henry Ford Hospital, Detroit
"Cardiovascular Complications"

David Flagler, MD, Practicing Neurologist, Kalamazoo
"Neurologic Complications of Diabetes"

John E. Gerich, MD, Associate Professor of Medicine an Physiology; Director, Diabetes and Metabolism Research Lab Departments of Medicine and Physiology, Mayo Clinic, Rochester, Minnesota
"New Developments in Diabetes — Update on Potential Ne Modes of Treatment (artificial pancreases and pancreati transplantation) and Evaluation of Diabetic Control (Hemoglobin A_1C)"

☐ Gastrointestinal and Pulmonary Endoscopy: A Review (Wet Clinic)

PRESENTED BY: Department of Medicine, Michigan Sta University College of Human Medicine

This course will provide the primary physician with practic information about the many recent advances in fiberoptic e doscopy. Course format will include short lectures, panel di cussions with audience participation, case presentations, ar demonstration of equipment. The course will describe rece advances in endoscopic techniques and equipment; discuss i dications and limitations; review specific examples of patho ogy; discuss the socio-economic impact of endoscopy ar demonstrate equipment using teaching manikins. Upon co pletion of the course, physicians will be familiar with rece technological advances in fiberoptic endoscopy, and be able logically apply these techniques to the diagnostic evaluation their patients.

COURSE DIRECTOR: James E. Mayle, MD, East Lansing

RESIDING: Doctor Mayle

PEAKERS/SUBJECTS:

oward A. Dean, DO, Assistant Professor of Medicine, Michi-
an State University College of Human Medicine
"Diagnostic Indications and Limitations of GI Endoscopy" (A Case Presentation)

avid S. Greenbaum, MD, Professor of Medicine, Michigan
tate University College of Human Medicine
"Cost Effectiveness of Gastrointestinal Endoscopy" (A Case Presentation)

ames E. Mayle, MD, Assistant Professor of Medicine, Michigan
tate University College of Human Medicine
"Brief Review of GI Endoscopy Equipment; Some Examples of Pathology"
"Colonoscopic Polypectomy"

amuel M. McMahon, MD, Associate Professor of Medicine,
lichigan State University College of Human Medicine; Direc-
or of Medical Education and Chief, Pulmonary Section, Ing-
am Medical Center, Lansing
"Indications and Limitations of Fiberoptic Bronchoscopy" (A Case Presentation)

ernard Schuman, MD, Clinical Associate Professor of Medi-
ne, University of Michigan Medical School, and Division
ead of Gastroenterology, Henry Ford Hospital, Detroit
"Endoscopic Retrograde Cholangio Pancreatography (ERCP) and Endoscopic Sphincterotomy"

☐ Management of Chronic Low Back Pain

ESENTED BY: Michigan Occupational Medical Association

is course is designed to provide specific and practical infor-
ation for all physicians in the management of chronic back
in. A thorough description of a multidisciplinary and holis-
approach will be given with special emphasis on neuro-
usculoskeletal and psychological theory of management of
ronic pain. Emphasis on current concepts of chronic pain
anagement, including appropriate referral, will be stressed.
rticipants will also learn clinical application of these newer
chniques.

URSE DIRECTOR: James M. Bullock, MD, East Lansing

ESIDING: Doctor Bullock

EAKERS/SUBJECTS:

mes M. Bullock, MD, Director, Pain Clinic, Ingham Medical
nter and Associate Professor, Department of Surgery, Michi-
n State University College of Human Medicine
"Role of Multidisciplinary Clinic in Management of Chronic Pain"

hn Jerome, PhD, Practicing Psychologist, Ingham Medical
in Clinic, Stress Management Inc.
"Psychological Evaluation and Treatment Applications"

ctor Bullock
"Use of Nerve Blocks in Treatment of Chronic Pain"

ctor Jerome
"Operant Conditioning and Muscular Relaxation Training for Chronic Pain"

lan Pool, RPT, Greater Lansing Rehabilitation Agency
"Use of Physical Therapies and Transcutaneous Electrical Nerve Stimulation (TENS) in Chronic Pain"

☐ Neurological Problems for the Primary Physician (Wet Clinic)

PRESENTED BY: Western Michigan Neurologic Society

This course on neurological problems will be aimed at acquainting primary care physicians with an approach to basic neurologic problems, including cranial cerebral trauma, headaches, neurological emergency and low back pain. The course will include a demonstration with a patient of the neurosurgeon's approach to the examination of the lumbar spine.

COURSE DIRECTOR: Oliver D. Grin, Jr., MD, Grand Rapids

PRESIDING: Doctor Grin

SPEAKERS/SUBJECTS:

John F. Butzer, MD, Practicing Neurologist, Grand Rapids, Department of Neurology, Michigan State University College of Human Medicine
"How to Evaluate Patients with Headaches"

Oliver D. Grin, Jr., MD, Associate Clinical Professor of Surgery, Michigan State University College of Human Medicine; President, Western Michigan Neurologic Society and Neurosurgeon, Blodgett Memorial Hospital, Grand Rapids
"A Neurosurgeon's Approach to Low Back Pain"

Leslie Neuman, MD, Practicing Neurologist, Grand Rapids
"How I Approach Neurologic Emergencies"

David A. Herz, MD, Practicing Neurosurgeon, Grand Rapids
"A Common Sense Approach to Head Injuries"

☐ Practical Approach to Electrolyte Problems

PRESENTED BY: Division of Nephrology, Henry Ford Hospital

This course will provide a practical approach to the management of common electrolyte and acid base disorders using actual patient histories which will be available before the course. After each patient has been discussed with and by the audience, a survey of current management will be presented.

COURSE DIRECTOR: Nathan W. Levin, MD, Division Head, Division of Nephrology, Henry Ford Hospital, Detroit, and Clinical Professor of Internal Medicine, University of Michigan Medical School

PRESIDING: Doctor Levin

SPEAKERS:

Robert Luke, MD, Professor of Medicine, Renal Division/Department of Medicine, University of Alabama School of Medicine, Birmingham

Pedro Cortes, MD, Staff Physician, Division of Nephrology, Henry Ford Hospital, Detroit

Francis Dumler, MD, Staff Physician, Division of Nephrology, Henry Ford Hospital, Detroit

K. K. Venkat, MD, Staff Physician, Division of Nephrology, Henry Ford Hospital, Detroit

Registration form page 19.

☐ Sports Medicine for Primary Care Physicians (Wet Clinic)

PRESENTED BY: The Michigan Orthopaedic Society

This course is designed for primary care physicians seeing patients on athletic fields, first aid facilities, hospital emergency rooms or their private offices. Emphasis will be on early diagnosis and appropriate treatment of athletic and recreational injuries. Demonstration of appropriate non-surgical techniques of treatment and rehabilitation will be featured. This course will close with a panel of the instructors answering questions.

CO-COURSE DIRECTORS: William T. Davison, MD, President, Michigan Orthopaedic Society; Practicing Orthopaedic Surgeon, Port Huron and **Gerald A. O'Connor, MD,** Director of Sports-Medicine Program, University of Michigan Medical Center

PRESIDING: Doctor O'Connor

SPEAKERS/SUBJECTS:

Dean S. Louis, MD, Associate Professor and Chief, Orthopaedic Hand Service, University of Michigan Medical School
"Hand Injuries Commonly Sustained by Athletes"
William Allen, MD, Professor of Orthopaedic Surgery, University of Missouri — Columbia School of Medicine, Columbia
"Knee and Ankle Injuries"
Eric T. Jones, MD, PhD, Instructor, Department of Surgery, Section of Orthopaedic Surgery, University of Michigan Medical School
"Epiphyseal Injuries in the Competitive and Recreational Athlete"
William Salot, MD, Assistant Clinical Professor of Orthopaedic Surgery, Wayne State University School of Medicine
"Runner's Problems"
Kathleen Heck, Athletic Trainer, Certified; Head Women's Trainer, Michigan State University Athletic Department
"The Proper Preparation and Care of the Female Athlete"

☐ The Use of CAT Scan in Making a Diagnosis Economically

PRESENTED BY: Department of Radiology, Michigan State University College of Human Medicine

This three hour course will cover the use of the CT scan in clinical medicine and research. It will be a comprehensive update of CT based both on published research and the extensive clinical experience of the speakers, and its content is appropriate for both radiologists and clinicians with CT experience, and for those wishing to familiarize themselves with the different aspects of the procedure. The course is divided into five segments covering the efficacy of CT, history and physics, head studies, body studies, and the effects of the use of CT on the medical community and society in general. Discussion will follow each presentation.

COURSE DIRECTOR: E. James Potchen, MD, East Lansing

PRESIDING: Doctor Potchen

SPEAKERS/SUBJECTS:

E. James Potchen, MD, Department of Radiology, Michigan State University College of Human Medicine
"The Use of Computed Tomography in Making a Diagnosi Economically"
James E. Siebert, MD, Department of Engineering and Radiology, Michigan State University College of Human Medicine
"History and Physics of Computed Tomography (CT) for th 'Medically Inclined' "
James E. Blackwell, MD, Assistant Professor, Department o Radiology, Michigan State University College of Huma Medicine
"CT of the Head"
Jack H. Harris, Jr., MD, Department of Radiology, Michiga State University College of Human Medicine
"CT of the Body"
Thomas S. Harle, MD, Professor, Department of Radiolog Michigan State University College of Human Medicine
"Medical and Social Implications of CT Scanning"

☐ Use of Psychoanalytic Knowledge in Medical Practice

PRESENTED BY: The Michigan Psychoanalytic Society

This course is for all physicians engaged in clinical practic Through the study of case vignettes, the holistic view of th patient as a total human being will be stressed, ablating th artificial division between psyche and soma. The mechanism whereby mental states are translated into alterations physiologic functions via autonomic nervous and endocrin pathways will be explored. The course will open with a bri overview and lectures followed by a discussion period. If a propriate, the class may be split into three separate discussi groups. Upon completion of this course, participants shoul be able to translate patients' symptoms into communicatio regarding what they are experiencing, they should understan the concepts of precipitating stress and personality predispos tion, and finally they should learn that treatment should i clude dealing with psychic factors which contribute to illnes Such an approach encourages collegial collaboration with ps chiatrists, while patient care remains in the hands of prima care physicians.

COURSE DIRECTOR: Lawrence P. Tourkow, MD, Huntingto Woods

PRESIDING: Doctor Tourkow

SPEAKERS/SUBJECTS:

Henry Krystal, MD, Professor of Psychiatry, Michigan Sta University College of Human Medicine
"The Emotional Component in All Illness: Its Recogniti and Handling, Both Prophylactically and Therapeutically"
Joseph Fischhoff, MD, Interim Chairman, Department Psychiatry and Professor of Child Psychiatry, Wayne State U versity School of Medicine
"The Prophylactic and Therapeutic Management of Ch dren's Reactions to Medical Illness and to Its Treatment"
Lawrence P. Tourkow, MD, Chief, Division of Gynecolog Psychiatry, Department of Gynecology and Obstetrics, Way State University School of Medicine
"Dealing with Psychic Reactions as an Essential Part of th Primary Medical Care of Women"

Wednesday and Thursday, Nov. 14 and 15

☐ Advanced Cardiac Life Support (A 16-hour course to run all day Wednesday and Thursday)

RESENTED BY: Michigan Chapter, American College of Emergency Physicians

This course is a nationally recognized training and certification program. It consists of lecture material and new concepts in raining and testing for the practical skills of Advanced Cardiac Life Support. Lectures will deal with adjuncts for airway and entilation, circulation, monitoring and dysrhythmia recogni- ion, defibrillation and synchronized cardioversion and establishment of IV's. The eight stations used to train the participants in ACLS skills are: basic life support (1 and 2 person CPR), adjuncts for airway, endotracheal intubation, esophageal intubation, placement of central venous catheters, ventricular fibrillation and defibrillation, recognition of dysrhythmias and drug therapy for dysrhythmias.

CO-COURSE DIRECTORS: Ann L. Harwood, MD, Butterworth Hospital, Grand Rapids, and **Eugene C. Grochowski, MD, PhD,** Clinical Faculty, Southwestern Michigan Area Health Education Center, Kalamazoo.

Courses Wednesday morning, Nov. 14

ALL COURSES RUN FROM 8:30 TO NOON WITH HALF-HOUR BREAK

☐ Alpha-Omega Session: Urinary Tract Infection in Children and Adults

RESENTED BY: Michigan Branch, American Urological As- ociation

pon completion of this course the family physician, pediatri- ian, internist and urologist will be familiar with the newest oncepts in the diagnosis and treatment of urinary tract infec- on in children and adults. Utilizing lectures, case presenta- ons and panel discussion, the different approaches to treat- ent of urinary infection in children vs. adults will be em- hasized, and a proper plan presented for the management of is disease in each age group.

OURSE DIRECTOR: Joseph C. Cerny, MD, Department of rology, Henry Ford Hospital, Detroit

RESIDING: Doctor Cerny

PEAKERS:

owell King, MD, Professor of Urology, Northwestern Univer- ty Medical School, Chicago

lan D. Perlmutter, MD, Professor of Urology, Wayne State niversity School of Medicine

ouis Saravolatz, MD, Staff Physician, Department of Infec- ous Diseases, Henry Ford Hospital, Detroit

ichard Klugo, MD, Department of Urology, Henry Ford Hospi- l, Detroit

ad Farah, MD, Department of Urology, Henry Ford Hospital, etroit

☐ Diagnosis and Treatment of Chronic Ear Disease for Primary Care Physicians

ESENTED BY: Department of Otolaryngology, Wayne State iversity School of Medicine

is course will provide primary physicians with practical owledge about the diagnosis and treatment of various forms chronic ear disease. Through both didactic presentations and panel discussion of questions from the audience, the course ticipant will become able to recognize and manage common nifestations of suppurative and non-supperative chronic ear ease.

URSE DIRECTOR: Sean B. Peppard, MD, Detroit

ESIDING: Doctor Peppard

SPEAKERS/SUBJECTS:

Sean B. Peppard, MD, Assistant Professor of Otolaryngology, Wayne State University School of Medicine
"Chronic External Ear Infections"

Arnold M. Cohn, MD, Professor, Wayne State University School of Medicine
"Serous Otitis Media — Acute and Chronic Effusion"

Dieter Wendling, MD, Clinical Assistant Professor of Otolaryngology, Wayne State University School of Medicine
"Chronic Suppurative Otitis Media — Diagnosis and Management"

Royal C. Hayden, MD, Clinical Associate Professor of Otolaryngology, Wayne State University School of Medicine
"Complications of Chronic Suppurative Otitis Media"

Panel: **Doctors Cohn, Hayden, Wendling, and Peppard**

☐ Management of Gastrointestinal Bleeding

PRESENTED BY: Michigan Society for Gastrointestinal Endoscopy

This course will provide a practical approach to the management of gastrointestinal bleeding. New and old therapies will be discussed so that decisions may be made on treatment, considering availability of therapeutic modalities. The course will be presented in two parts and a panel discussion will follow each portion.

COURSE DIRECTOR: John P. Papp, MD, Grand Rapids

PRESIDING: Robert D. Brouwer, MD, Associate Clinical Professor of Medicine, Michigan State University College of Human Medicine and **William A. Gracie, MD,** Associate Clinical Professor of Internal Medicine, University of Michigan Medical School

SPEAKERS/SUBJECTS:

First Session (including panel discussion):

Donald H. Kuiper, MD, Associate Clinical Professor of Medicine, Michigan State University College of Human Medicine
"General Approach to the Management of Upper Gastrointestinal Bleeding"

Glen R. Hiller, MD, Assistant Clinical Professor of Medicine, Wayne State University School of Medicine
"Tagamet Update"

David H. Wiedemer, MD, Gastroenterologist, Edward W. Sparrow Hospital, Lansing
"X-ray vs. Endoscopy in Diagnosis of Upper Gastrointestinal Bleeding Sites"

Eugene A. Gelzayd, MD, Associate Clinical Professor of Medicine, Wayne State University School of Medicine
"Managment of Hemorrhagic Erosive Gastritis"

John P. Papp, MD, Associate Clinical Professor of Medicine, Michigan State University College of Human Medicine
"The Visible Vessel and Electrocoagulation"

Edmund Martin Barbour, MD, Associate Clinical Professor of Medicine, Wayne State University School of Medicine
"The Blakemore-Sengstaken Tube in the Treatment of Esophageal Varices"

Second Session (including panel discussion):

Arthur Klass, MD, Assistant Clinical Professor of Medicine, Wayne State University School of Medicine

Ray Joseph, MD, Professor of Internal Medicine, University of Michigan Medical School and Director, Wayne County General Hospital
"Pros and Cons of Vasopressin in the Treatment of Esophageal Varices"

Larry J. Robson, MD, Associate Clinical Professor of Surgery, Michigan State University College of Human Medicine
"Surgical Treatment of Esophageal Varices"

Gustav A. Uhlich, MD, Chief of Gastrointestinal Service, Burns Clinic, Petoskey, and **Doctor Gracie**
"The Approach to Lower Gastrointestinal Bleeding"

☐ Management of Premalignant Breast Disease

PRESENTED BY: Michigan Academy of Plastic Surgeons

This in-depth course is planned to try and clarify the many controversial aspects of the management of premalignant breast disease for physicians who manage patients with this potential problem. On completion of this course, it is hoped that participants will have a clear idea of the current concepts in basic pathology, radiologic identification and significance, indications for operation, and surgical techniques and complications. These subjects will be discussed in a series of 15-30 minute lectures. Following this, a one-hour panel discussion will include all the participants; a pathologist, radiologist, general surgeon/oncologist, and an internationally famous plastic surgeon.

COURSE DIRECTOR: Robert M. Oneal, MD, Ann Arbor

PRESIDING: Doctor Oneal

SPEAKERS/SUBJECTS:

Harold A. Oberman, MD, Professor of Pathology, University of Michigan Medical School
"Delineation of Pathologic Classification and Relative Risk of Premalignant Breast Lesions"

John N. Wolfe, MD, Chairman, Department of Radiology, Hutzel Hospital, Detroit
"Radiologic Identification of the High Risk Patient with Pathologic Correlation"

John E. Niederhuber, MD, Associate Professor of Surgery, Section of General Surgery, University of Michigan Medical School
"A General Surgeon's/Oncologist's Point of View Regarding Preventative or Prophylactic Mastectomy: When, How, Minimum Standards"

Charles E. Horton, MD, Chairman and Professor, Department o Plastic Surgery, Eastern Virginia School of Medicine and Director of Eastern Virginia Graduate School of Medicine, Norfolk
"Technique and Problems of Primary Reconstruction"

Robert M. Oneal, MD, Clinical Associate Professor of Surgery, Section of Plastic Surgery, University of Michigan Medical School
"Indications and Results of Delayed Reconstruction Afte Prophylactic Mastectomy — Including the Economic Point o View"

☐ Mechanical Ventilation in Acute Respiratory Failure — Newer Techniques

PRESENTED BY: Pulmonary Division, University of Michiga Medical School

This course will provide primary care physicians with curren knowledge of criteria for intubation and mechanical ventilation. It will critically review newer methods of mechanical ventilation so that the physician may intelligently select the mos appropriate for patients in acute respiratory failure of variou etiologies. It will review the causes of superimposed cardiopulmonary collapse ("disasters") during mechanical ventilation and provide a decision-making tree for their identification and treatment. It will provide criteria for weaning and extubation and critically review the various weaning approache Upon completion of this course the physician will be able to: 1 identify patients requiring intubation and mechanical ventilation; 2) select the appropriate mode of ventilation; 3) identif and know how to resolve common emergencies durin mechanical ventilation, and 4) identify the readiness of a patient for weaning and extubation. A pre and post test will provide immediate feedback on increase in knowledge.

COURSE DIRCTOR: John G. Weg, MD, Ann Arbor

PRESIDING: Doctor Weg

SPEAKERS/SUBJECTS:

Joseph P. Lynch, III, MD, Assistant Professor of Interna Medicine, University of Michigan Medical School
"When to Intubate and Ventilate (Decision Making at th Bedside)"

Philip C. Hopewell, MD, Assistant Professor of Medicine, Un versity of California at San Diego, School of Medicine
"Advantages and Disadvantages of Newer Mechanical Ve tilatory Techniques: e.g. IMV CPAP"

John G. Weg, MD, Professor of Internal Medicine; Physicia In-Charge, Pulmonary Division, University of Michigan Med cal School
"Disaster Drill During Mechanical Ventilation (when pre sure alarms buzz, blood pressure disappears, etc.)"

David R. Dantzker, MD, Assistant Professor, Internal Medicin University of Michigan Medical School
"When and How to Wean from Mechanical Ventilation ar Extubate"

☐ Office Dermatology for the Non-Dermatologist

PRESENTED BY: Michigan Dermatological Society and D partment of Dermatology, Wayne State University School Medicine

This course will utilize speakers and panel discussions to en ble the practicing physician to recognize common dermatos to know what lab tests to order, and how to manage comm disorders with various treatment modalities. Specific subje

Vednesday morning/continued

hat will be covered are common adult and pediatric der-natoses, contact dermatitis, pigment disorders of the skin and ife-threatening dermatoses.

:OURSE DIRECTOR: Thomas F. Downham, II, MD, Detroit

'RESIDING: Doctor Downham

PEAKERS/SUBJECTS:

ames Stroud, MD, Clinical Assistant Professor, Department of)ermatology, Wayne State University School of Medicine
"The Ten Most Common Dermatoses"
yed L. Husain-Hamzavi, MD, Associate Professor, Department f Dermatology, Wayne State University School of Medicine
"Primary Irritant vs. Allergic Contact Dermatitis"
Iichael B. Brodin, MD, Assistant Professor, Department of)ermatology, Wayne State University School of Medicine
"The Ten Most Common Pigment Disorders of the Skin"
arold M. Wagenberg, MD, Chief Resident, Department of)ermatology, Wayne State University School of Medicine
"The Ten Most Common Pediatric Dermatoses"
homas F. Downham, II, MD, Assistant Professor, Department f Dermatology, Wayne State University School of Medicine
"Life-Threatening Dermatoses"

☐ Pediatric and Adolescent Gynecology

RESENTED BY: Michigan Society of Obstetricians and Gyne-ologists and Michigan Section, American College of Obstetri-ans and Gynecologists

he course will present to the generalist and specialist a short verview of pediatric and adolescent gynecology followed by ree 40-minute lectures covering gynecologic endocrinology, ncology, and psychiatry in the pediatric and adolescent pa-ent.

OURSE DIRECTOR: Donald T. Olson, MD, Detroit

RESIDING: Doctor Olson

PEAKERS/SUBJECTS:

onald T. Olson, MD, President, Michigan Society of Obstetri-ans and Gynecologists and Clinical Instructor of Obstetrics d Gynecology, Wayne State University School of Medicine
"Common Pediatric and Adolescent Gynecologic Problems in Private Practice"
illiam S. Floyd, MD, Associate Professor of Obstetrics and ynecology, Wayne State University School of Medicine
"Pediatric and Adolescent Gynecologic Endocrinolgy"
lian P. Smith, MD, Professor of Obstetrics and Gynecology, ayne State University School of Medicine
"Pediatric and Adolescent Gynecologic Oncology"
even J. Engelberg, MD, Clinical Faculty, Department of sychiatry, Division of Child Psychiatry, University of ashington School of Medicine, Seattle
"Pediatric and Adolescent Gynecologic Psychiatry"

☐ Physician Role in Cost-Effective Medical Care

PRESENTED BY: MSMS Committee on Medical Care Costs

This course will discuss the medical profession's desires to improve the quality of patient care while making the most efficient use of all resources. The physicians attending will become more aware of the costs (direct and indirect) of a variety of medical activities. Efforts of the AMA and MSMS and the Michigan Hospital Association to serve their patients in a more cost-effective manner will be presented. Ways in which the individual physician may improve care for ambulatory and hospitalized patients while limiting and/or reducing costs will be suggested.

COURSE DIRECTOR: R. Jack Chase, MD, Grand Rapids

PRESIDING: Doctor Chase

SPEAKERS/SUBJECTS:

R. Jack Chase, MD, Chairman, MSMS Task Force on Medical Care Costs
"Cost Awareness Overview"
Luis A. Tomatis, MD, Cardiovascular Surgeon, Butterworth Hospital, Grand Rapids
"One Method for Rationalized Expenses in Surgery"
Kenneth E. Raske, Vice President, Health, Economics and Finance, Michigan Hospital Association, Lansing
"Hospital Cost Containment"
Arthur F. Kohrman, MD, Associate Dean for Educational Programs, Michigan State University College of Human Medicine
"Education for Cost Effective Medical Decision Making"
Armen Shekerjian, MD, Medical Director of Professional Affairs, Blue Cross/Blue Shield of Michigan, Detroit
"Second Surgical Opinions"

☐ Stresses Within the Physician's Family

PRESENTED BY: Michigan Psychiatric Society and the MSMS Auxiliary

This course will provide an opportunity for physicians and spouses to examine the stresses particular to those individuals whose lives are affected by the demands of the medical profession. The format will be a panel of physicians and family members who will share their perspectives. There will be opportunity for small group discussion with panelists as facilitators. Participants will gain a clearer idea of what stresses to anticipate and how to identify assistance for major problems

COURSE DIRECTOR: Gail M. Barton, MD, Ann Arbor

PRESIDING: Doctor Barton

SPEAKERS/SUBJECTS:

Gail M. Barton, MD, Associate Professor of Psychiatry, University of Michigan Medical School
"Woman Physician in the Family"
Thomas E. Bittker, MD, Director of Health Maintainence Services, Arizona Health Plan and Chairman, Division of Psychiatric Education, Phoenix
"The Impaired Physician"
Mildred Carron, President of the MSMS Auxiliary, Ann Arbor
"Stresses Which Arise in the Family of a Physician"
Douglas A. Sargent, MD, President, Michigan Psychiatric Society; Clinical Associate Professor of Psychiatry and Adjunct Professor of Law, Wayne State University
"Job and Career Demands Versus Family Responsibilities"

☐ What's New in Allergy and Asthma in Children

PRESENTED BY: Michigan Allergy Society and Michigan Chapter, American Academy of Pediatrics

The instructors will present six topics concerning allergy and asthma in children. The subjects will include: 1) New Drug Treatment in Asthmatic Children, 2) Venom Therapy in the Treatment of Bee Sting Hypersensitivity, 3) Value of Total IgE and Allergen-Specific Antibody (RAST) Determination in the Diagnosis of Allergy, 4) Exercise-Induced Asthma in Young Athletes, 5) Gastroesophageal Reflux-Induced Pulmonary Disease in Infants, 6) Practical Comments on "What's New in the Office Management of the Allergic Child."

COURSE DIRECTOR: John A. Anderson, MD, Detroit

PRESIDING: Doctor Anderson

SPEAKERS/SUBJECTS:

R. Michael Sly, MD, Chairman, Allergy and Immunology, Children's Hospital and National Medical Center, Washington, D.C.
"Newer Drug Treatment in Asthmatic Children"

Robert W. Clausen, MD, Staff Physician, Division of Allergy and Clinical Immunology, Henry Ford Hospital, Detroit
"Venom Therapy in the Treatment of Bee Sting Hypersensitivity"

John A. Anderson, MD, Head, Division of Allergy and Clinical Immunology, Henry Ford Hospital, Detroit
"Value of Total IgE and Allergen-Specific Antibody (RAST) Determination in the Diagnosis of Allergy"

Doctor Sly
"Exercise-Induced Asthma in Young Athletes"

Jorge Abarzua, MD, Staff Physician, Division of Allergy and Clinical Immunology, Henry Ford Hospital, Detroit
"Gastroesophageal Reflux-Induced Pulmonary Disease in Infants"

Doctor Anderson
"Practical Comments on What's New in the Office Management of the Allergic Child"

☐ What's New in Antibiotics and Common Office Infections

PRESENTED BY: Department of Medicine, Wayne State University School of Medicine

Common office infections are: pharyngitis, bronchitis, furunculosis, urinary tract infection, urethritis, vaginitis and cervicitis. Clinical and microbiological diagnosis as well as curren therapy with newer antibiotics including amoxicillin, newe cephalosporins, tetracycline, trimethoprim and sulfamethazol will be delineated for the primary care provider including family doctors, internists, gynecologists, and surgeons.

COURSE DIRECTOR: A. Martin Lerner, MD, Detroit

PRESIDING: Doctor Lerner

SPEAKERS:

Harold C. Neu, MD, Professor of Medicine, Columbia Unive sity College of Physicians and Surgeons, New York

Carl B. Lauter, MD, Assistant Professor of Internal Medicin Wayne State University School of Medicine

Donald P. Levine, MD, Professor of Biology, Wayne State Un versity School of Medicine

Milagros P. Reyes, MD, Associate Professor of Medicin Wayne State University School of Medicine

Lawrence Crane, MD, Assistant Professor of Medicine, Wayn State University School of Medicine

A. Martin Lerner, MD, Professor of Medicine, Wayne Sta University School of Medicine

56 COURSES OFFER 3 HOURS EACH OF CATEGORY 1 CREDIT

Complete and return registration form on page 19

Courses Wednesday afternoon, Nov. 14

ALL COURSES RUN FROM 1:30 TO 5 P.M. WITH HALF-HOUR BREAK

☐ Alpha-Omega Session: Hematuria

RESENTED BY: Michigan Branch, American Urological Asociation

his course, through lectures and case presentations, will emhasize similarities and differences in treating pediatric and dult patients with hematuria; thereby aiding the primary care hysician in evaluating and treating all age groups with this roblem.

OURSE DIRECTOR: Gerald F. Conway, MD, Royal Oak, Secetary, Michigan Branch, American Urological Association

RESIDING: Richard Dorr, MD, Ann Arbor, Clinical Associate rofessor of Surgery, University of Michigan Medical School

PEAKERS/SUBJECTS:

tephen Koff, MD, Assistant Professor of Surgery and Chief of ediatric Urological Services, University of Michigan Medical chool
"Children with Hematuria"

oseph Oldford, MD, Assistant Professor of Urology, Wayne tate University School of Medicine, and Chief of Urology, arper-Grace Hospital, Detroit
"Non-traumatic Hematuria in Adults"

dson Pontes, MD, Associate Professor of Urology, Wayne State niversity School of Medicine and Chief of Urology, Detroit eneral Hospital
"The Importance of Hematuria Following Trauma"

aurence F. Greene, MD, PhD, Professor of Clinical Surgery/ rology, University of California, San Diego, School of edicine
"Hematuria — An Overview"

☐ Bronchial Asthma in Adults: Diagnosis and Management

RESENTED BY: Michigan Allergy Society

his course will provide a general approach to the management f asthmatic patients. First consideration will be given to the ecognition and evaluation of airways obstruction. The several recipitating factors will be reviewed together with their echanisms of producing bronchial constriction. The role of llergic factors in asthma will be discussed as well as means of heir clinical and laboratory evaluation. This will be followed y a stepwise description of the treatment of an acute asthmatic ttack ranging from initial office procedures to the hospital anagement of status asthmaticus. Turning to the long treatent, special consideration will be given to relatively new ethods of therapy.

OURSE DIRECTOR: Timothy A. Smith, MD, Saginaw, Presient, Michigan Allergy Society

RESIDING: Kenneth P. Mathews, MD, Ann Arbor

PEAKERS/SUBJECTS:

lliott Middleton, Jr., MD, Professor of Medicine and Pediatcs, and Director Division of Allergy, State University of New ork, at Buffalo School of Medicine
"Evaluation of The 'Intrinsic' Asthmatic"

Kenneth P. Mathews, MD, Professor of Internal Medicine and Head, Division of Allergy, University of Michigan Medical School
"Evaluation of The Allergic Asthmatic"

Murray R. O'Neil, MD, Practicing Allergist and Internist, Windsor, Ontario
"Treatment of Acute Asthma"

☐ Cutaneous Manifestations of Systemic Disease — Lupus Erythematosus

PRESENTED BY: Michigan Dermatological Society and Department of Dermatology, Wayne State University School of Medicine

This course will review current progress in the diagnosis, immune workup and therapeutic management of cutaneous and systemic lupus erythematosus. Use of direct immunofluorescence for differentiating discoid (cutaneous) lupus erythematosus versus systemic lupus erythematosus will be presented. In systemic lupus erythematosus, emphasis on anti-DNA antibodies, direct immunofluorescence and lupus nephritis will be correlated by the speaker. A panel discussion with questions from the audience will follow the talks.

COURSE DIRECTOR: Thomas F. Downham, II, MD, Assistant Professor of Dermatology, Wayne State University School of Medicine

PRESIDING: Doctor Downham

SPEAKERS/SUBJECTS:

James N. Gilliam, MD, Associate Professor of Dermatology, Department of Internal Medicine, The University of Texas Health Science Center Southwestern Medical School at Dallas
"The Clinical Spectrum of Lupus Skin Disease"

Denny L. Tuffanelli, MD, Clinical Associate Professor, Department of Dermatology, University of California, San Francisco, School of Medicine
"Management of Patients with Cutaneous Lupus Erythematosus and some Erythematosus Variants"

☐ "Doctor, Why Did You Cancel My Case?"

PRESENTED BY: Michigan Society of Anesthesiologists

This course is intended for all physicians taking care of patients who may need surgery. Through case presentation, 20-minute talks and panel discussions, the major reasons for preoperative cancellation of surgery will be reviewed. Upon completion of this course, the physician should be able to properly prepare patients with diabetes, hypertension, electrolyte imbalance, and cardiac, hepatic and pulmonary disease for surgery.

COURSE DIRECTOR: Gaylord D. Alexander, MD, Detroit

PRESIDING: Doctor Alexander

SPEAKERS/SUBJECTS:

Peter J. Cohen, MD, Professor and Chairman of the Department of Anesthesiology, University of Michigan Medical School
"Management of the Patient with Liver Disease for Anesthesia and Surgery"

John R. Ammon, MD, Attending Anesthesiologist, St. John Hospital, Detroit
"Management of the Patient with Cardiac Disease for Anesthesia and Surgery"
Gaylord D. Alexander, MD, Attending Anesthesiologist, Sinai Hospital and Associate Professor of Anesthesiology, Wayne State University School of Medicine
"Management of the Patient with Electrolyte Imbalance for Anesthesia and Surgery"
Kathleen E. Chase, MD, Attending Anesthesiologist, St. Mary's Hospital, Grand Rapids
"Management of the Patient with Diabetes for Anesthesia and Surgery"
Eli M. Brown, MD, Professor and Chairman of the Department of Anesthesiology, Wayne State University School of Medicine and Sinai Hospital, Detroit
"Management of the Patient with Pulmonary Disease for Anesthesia and Surgery"

☐ Inflammatory Bowel Disease

PRESENTED BY: Michigan Society of Colon and Rectal Surgeons

This course intends to help physicians recognize the clinical features of inflammatory bowel disease and its various elements and differentiate ulcerative colitis and Crohn's disease. The course will review the proper methods of medical treatment in diagnosis and long-term management and will also discuss the proper role of surgery in treatment of Crohn's disease. It should provide family physicians and surgeons with a knowledge of the current findings and concepts for proper management of the inflammatory bowel diseases.

COURSE DIRECTOR: John M. MacKeigan, MD, Grand Rapids, Practicing Colon and Rectal Surgeon, Ferguson Clinic

PRESIDING: Doctor MacKeigan

SPEAKERS/SUBJECTS:

William L. Beauregard, MD, Chief, Colon and Rectal Surgery, William Beaumont Hospital, Royal Oak
"Endoscopic Findings in Inflammatory Bowel Disease"
Konstantin R. Loewig, MD, Staff Radiologist, Holland Community Hospital, Holland
"Radiologic Findings in Inflammatory Bowel Disease"
W. Patrick Mazier, MD, Associate Clinical Professor of Surgery, Michigan State University College of Human Medicine and Staff, Ferguson-Droste-Ferguson Hospital, Grand Rapids
"Extra Intestinal Manifestations of Inflammatory Bowel Disease"
Jack G. Lukens, MD, Associate Clinical Professor of Medicine, Michigan State University College of Human Medicine and Gastroenterologist, Butterworth Hospital, Grand Rapids
"Medical Treatment of Inflammatory Bowel Disease"
Victor W. Fazio, MD, Chairman, Department of Colon and Rectal Surgery, Cleveland Clinic, Cleveland
"Surgical Treatment of Crohn's Disease"

☐ Nuclear Medicine — Its Practical Value

PRESENTED BY: Michigan College of Nuclear Medicine Physicians

This course is designed to introduce the referring physician to currently used techniques and applications in diagnostic Nuclear Medicine. Special emphasis will be placed on its role in the early detection of pulmonary embolism, acute cholecystitis various neurologic diseases and coronary artery disease.

COURSE DIRECTOR: John E. Freitas, MD, Royal Oak

PRESIDING: Doctor Freitas

SPEAKERS/SUBJECTS:

Manuel L. Brown, MD, Assistant Professor of Radiology an Nuclear Medicine, Mayo Clinic, Rochester, Minnesota
"The True Current Status of Lung Ventilation Perfusio Studies in Pulmonary Embolism"
John E. Freitas, MD, Clinical Assistant Professor of Interna Medicine, University of Michigan Medical School and staff William Beaumont Hospital, Royal Oak
"Hepatobiliary Imaging — Its Role in Biliary Tract Disease"
Darlene Fink-Bennett, MD, Clinical Assistant Professor c Radiology, Michigan State University College of Huma Medicine and staff, William Beaumont Hospital, Royal Oak
"The Brain Scan — Should it be Replaced by Computerize Tomography?"
James H. Thrall, MD, Associate Professor of Internal Medicin and Radiology, University of Michigan Medical School
"Gated Cardiac Blood Pool Imaging Versus Stress Thalliur Imaging: Detection of Coronary Artery Disease"

☐ Otolaryngological Diseases: Latest Advances in Technique and Management

PRESENTED BY: Michigan Otolaryngological Society

This course, which will be presented by the Otolaryngolog Departments of the University of Michigan Medical School Henry Ford Hospital, and Wayne State University School o Medicine, is oriented to the advancements in diagnosti methods and management of common and also perplexing entities in ear, nose, and throat. The presentations will b supplemented with audio-visual aids and panel discussions There will also be an opportunity for active audience participation with questions and answers.

COURSE DIRECTOR: John W. Grigg, MD, Bay City, President Michigan Otolaryngological Society

PRESIDING: Doctor Grigg

SPEAKERS/SUBJECTS:

Charles J. Krause, MD, Professor and Chairman, Department o Otolaryngology, University Hospital, University of Michiga Medical School
Richard D. Nichols, MD, Chief, Department of Otolaryngology Henry Ford Hospital, Detroit
"Malignant External Otitis, and Meningioma In The Neck"
Robert Mathog, MD, Chairman, Department of Otolaryngology Wayne State University School of Medicine

☐ Psychology of Abortion

PRESENTED BY: Michigan Psychiatric Society

This course will present the controversial procedure of abortio from the historical, psychological, medical, societal, economi and legal aspects, including the recent juridical conflicts. Th course will be aimed primarily at physicians and their vulnera ble position as it relates to this subject throughout history. Th panel participants will assume no position either pro or co and ample time will be allowed for audience participation.

COURSE DIRECTOR: Ruth S. Day, MD, Detroit, Practicin Psychiatrist

'RESIDING: Linda Logsdon, MD, Southfield, Practicing 'sychiatrist

;PEAKERS/SUBJECTS:

)orothy Bloch, MA, Psychoanalyst, National Psychological Asociation for Psychoanalysis and author of *So The Witch Won't 'at Me*
"So The Witch Won't Eat Me"

Ionorable Hilda Gage, Pontiac, Oakland County Circuit Court udge
"The Legal Aspects of Abortion"

. Alberto Hodari, MD, Obstetrics and Gynecology, Detroit Iemorial Hospital
"The Socioeconomic Side of Abortion"

oseph Fischhoff, MD, Child Analyst and Professor of Pediatric sychiatry, Wayne State University School of Medicine, Chilren's Hospital, Detroit
"The Unwanted Child"

☐ Reconstruction Following Mastectomy for Cancer of the Breast

RESENTED BY: Michigan Academy of Plastic Surgeons

his is an advanced course designed for primary care physians as well as surgical specialists who are responsible for paents who have had or who will need mastectomy for breast ıncer. At the conclusion of the course, it is planned that parcipants will take away a clear understanding of the basic incations and the various surgical techniques including priary and delayed reconstruction after radical and modified dical mastectomy. Non-surgical techniques, and the use of kternal prostheses will also be discussed and demonstrated. A ıestion and answer period will follow a series of 20-30 minute ctures. Faculty will include a general surgeon oncologist, two astic surgeons, and a medical sculptor.

OURSE DIRECTOR: Robert M. Oneal, MD, Clinical Associate ofessor of Surgery, Section of Plastic Surgery, University of ichigan Medical School

RESIDING: Doctor Oneal

'EAKERS/SUBJECTS:

ıarles E. Horton, MD, Chairman and Professor, Department of astic Surgery, Eastern Virginia School of Medicine and Direcr of Eastern Virginia Graduate School of Medicine, Norfolk
"Indications of Reconstruction"

hn E. Niederhuber, MD, Associate Professor of Surgery, Secon of General Surgery, University of Michigan Medical hool
"Primary Reconstruction"

. Peter McCabe, MD, Clinical Assistant Professor of Surgery d Medicine, Wayne State University School of Medicine
"Delayed Reconstruction After Modified Radical Mastectomy"

octor Horton
"Reconstruction After Standard Radical Mastectomy Including Nipple and Areolae Complex"

nis C. Lee, MD, Director, Medical Sculpture Service and Astant Professor of Plastic Surgery; Associate Professor of Art d Postgraduate Medicine, University of Michigan Medical hool
"External Breast Prostheses"

☐ What's New in Common Pediatric Problems

PRESENTED BY: Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

This course will cover recent advances in areas of pediatric care which will be of interest and value to primary care physicians. Included will be an update on common pediatric infections and a survey of common pediatric problems — developmental, orthopedic, behavioral, surgical. Discussion will also include diagnosis and management and some current thinking on when intervention is not indicated.

COURSE DIRECTOR: George H. Baker, Jr., MD, Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

PRESIDING: Doctor Baker

SPEAKERS/SUBJECTS:

Margaret C. Heagarty, MD, Associate Professor of Pediatrics, Columbia University College of Physicians and Surgeons, New York, and Director of Pediatrics, Harlem Hospital Center, New York
"Survey of Common Pediatric Problems"

Dennis Murray, MD, Assistant Professor of Pediatrics and Human Development, Section of Infectious Diseases, Michigan State University College of Human Medicine
"Update on Common Pediatric Infections"

☐ What's New in Evaluation of the Dizzy Patient

PRESENTED BY: University of Michigan Medical School and Wayne State University School of Medicine

This course will include detailed step by step approaches to evaluating the dizzy patient from history, physical, audiometric and laboratory aspects. Treatment and diagnosis will also be discussed.

COURSE DIRECTOR: Eugene Rontal, MD, Clinical Assistant Professor, Department of Otorhinolaryngology, University of Michigan Medical School, and Clinical Assistant Professor, Wayne State University School of Medicine

PRESIDING: Doctor Rontal

SPEAKERS/SUBJECTS:

Michael Rontal, MD, Clinical Assistant Professor, Department of Otorhinolaryngology, University of Michigan Medical School and Clinical Assistant Professor, Wayne State University School of Medicine
"Laboratory Studies"

Harry J. Richter, MD, Clinical Assistant Professor, Department of Otorhinolaryngology, University of Michigan Medical School
"Physical Exam"

Joan B. Wilkoff, MA, Clinical Audiologist, Southfield
"Audiologic Exam"

Conrad A. Proctor, MD, Practicing Otorhinolaryngologist, William Beaumont Hospital, Southfield
"Diagnosis"

John C. Webster, MD, Clinical Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine
"Treatment"

Courses Thursday morning, Nov. 15

ALL COURSES RUN FROM 8:30 TO NOON WITH HALF-HOUR BREAK

☐ Diagnosis and Management of Monoarticular Arthritis

PRESENTED BY: Division of Rheumatology, Wayne State University School of Medicine

This course will familiarize the primary care physician with a step-wise approach to the diagnosis and management of acute and chronic monoarticular arthritis. Topics to be covered are: 1) differential diagnosis between gout, pseudogout and infectious arthritis; 2) common clinical problems such as what to do when infection is suspected, the gram stain is negative and the cultures are pending or when both gram stain and culture are negative; 3) approach to the diagnosis of chronic monoarticular arthritis; 4) management of monoarticular arthritis of uncommon etiology.

COURSE DIRECTOR: Jose L. Granda, MD, Detroit

PRESIDING: Doctor Granda

SPEAKERS/SUBJECTS:

Martin Atdjian, MD, Assistant Professor of Medicine, Division of Rheumatology and Clinical Immunology, Wayne State University School of Medicine
"Approach to the Diagnosis of Monoarticular Arthritis"
Jose L. Granda, MD, Associate Professor of Medicine, Division of Rheumatology and Clinical Immunology, Wayne State University School of Medicine
"Gout and Pseudogout"
Felix Fernandez-Madrid, MD, Professor of Medicine, Chief, Division of Rheumatology and Clinical Immunology, Wayne State University School of Medicine
"Approach to the Patient with the Septic Joint"
Samuel Indenbaum, MD, Assistant Clinical Professor of Medicine, Department of Internal Medicine, Wayne State University School of Medicine
"Uncommon Causes of Monoarticular Arthritis (Including Unusual Infections)"

☐ Ethical Issues in Medicine

PRESENTED BY: Medical Humanities Program, Michigan State University College of Human Medicine

Medical ethics involves the identification, analysis, and evaluation of value conflicts that arise in the context of medicine. More an activity than a body of knowledge, it requires the application of various skills in analytic reasoning and an understanding of the complex relationships between ethics, law, and religion in a pluralistic society. The course will therefore begin with a brief review of the analytic skills and understanding involved in ethical inquiry. A videotape will then be presented in which a severely burned young man requests that his treatment be stopped and that he be allowed to go home and die. The course will then divide into small groups, each coordinated by one of the speakers, for give-and-take discussion of how this man ought to be treated. The small groups will then come together to report the results of their deliberations.

COURSE DIRECTOR: Andrew D. Hunt, MD, Coordinator, Medical Humanities Program, Michigan State University College of Human Medicine

PRESIDING: Doctor Hunt

SPEAKERS:

Martin Benjamin, PhD, Professor of Philosophy, and Assistar Coordinator for Medical Humanities, Michigan State Universit College of Human Medicine
Bruce L. Miller, PhD, Associate Professor, Department c Philosophy, Michigan State University
Dan C. English, MD, Professor and Chairman, Department c Surgery, Michigan State University College of Human Mec icine
Arnold Werner, MD, Professor, Department of Psychiatr Michigan State University College of Human Medicine

☐ New Concepts in Congestive Heart Failure

PRESENTED BY: Michigan State University College of Huma Medicine

The objectives of this course are to reinforce the physician' understanding of mechanisms responsible for congestive hea failure, principles underlying the usual therapy and details re garding the treatment. Emphasis will be placed on recen techniques of value in diagnosis and in assessment of the effec tiveness of treatment. The course also will include an outline c newer methods of therapy — specifically the use of vas odilators and a discussion of drug and non-drug aspects c treatment.

COURSE DIRECTOR: Park W. Willis, MD, East Lansing

PRESIDING: Doctor Willis

SPEAKERS/SUBJECTS:

Park W. Willis, III, MD, Director of Division of Cardiolog Michigan State University College of Human Medicine
Raymond H. Murray, MD, Chairman, Department of Medicin Michigan State University College of Human Medicine
"Non-Pharmacologic Measures in the Treatment of Hea Failure"
John W. Jones, MD, Professor of Medicine, Educational Pro grams, Department of Human Medicine, Michigan State Univer sity College of Human Medicine
"Echocardiograph Assessment and Follow-Up"
Walter Baird, MD, Associate Professor of Cardiology, Michiga State University College of Human Medicine and Directo Heart Station, Ingham Medical Center, Lansing
"Pharmacology Follow-Up and Heart Failure"

☐ Ophthalmology's Role in Medicine (Wet Clinic)

PRESENTED BY: Michigan Ophthalmological Society

This course, with emphasis on practical application, will dis cuss the role of ophthalmology in total patient care. Include will be presentations on eye injuries and disease, as well a examinations. A lecture and demonstration on the use of th ophthalmoscope will be given and plans are being made for et lab with models for participant use. A question and answer eriod will follow each lecture.

OURSE DIRECTOR: Frederick W. Bryant, MD, Practicing phthalmologist, William Beaumont Hospital, Royal Oak

RESIDING: Doctor Bryant

PEAKERS/SUBJECTS:

avid Barsky, MD, Ocular Pathologist, Eye Clinic of Wyan- otte; Department of Pathology, William Beaumont Hospital; epartment of Ophthalmology, Henry Ford Hospital, Detroit
"Injuries of Eye in Orbit"
onrad L. Giles, MD, Practicing Pediatric Ophthalmologist and taff, Children's Hospital of Michigan, Detroit
"Eye Exam of the Child"
aniel L. Steen, MD, Department of Ophthalmology, Henry ord Hospital, Detroit
"Glaucoma"
"Explanation of the Use of an Ophthalmoscope"
illiam C. Albert, MD, Cornea and External Disease Service, illiam Beaumont Hospital and Sinai Hospital of Detroit
"The Red Eye"
octor Giles
"Is This Referral Routine, Urgent or Emergent?"
octor Barsky
"The Wet Eye"
atrick L. Murphy, MD, Associated Retinal Consultant, Wil- am Beaumont Hospital, Detroit
"The Retina in Diabetes"

☐ Preventive Cardiology — The Primary Care Mission

RESENTED BY: Department of Human Development, Michi- n State University College of Human Medicine

his course will provide practical information and guidelines r assessing individual and family risk of coronary artery dis- se — present and future. Total risk will be examined in its mponent contributions made by genetic, environmental, nu- itional and social factors. The need for preventive interven- on at an early age will be outlined with practical proposals for s attainment through comprehensive, informed and indi- dualized counseling in physical fitness, nutrition, exercise, garette avoidance, and emotional and social development.

OURSE DIRECTOR: Albert W. Sparrow, MD, East Lansing

RESIDING: Doctor Sparrow

PEAKERS:

obert Curtis Ellison, MD, Director, Division of Preventive rdiology, Children's Hospital Medical Center, Boston
mes E. Trosko, PhD, Professor, Department of Pediatrics and uman Development, Michigan State University College of uman Medicine
ichael Netzloff, MD, Associate Professor, Department of diatrics and Human Development, Michigan State University llege of Human Medicine
bert W. Sparrow, MD, Professor, Department of Pediatrics d Human Development, Michigan State University College of man Medicine

☐ Understanding and Treating Alcoholism and Drug Dependence

PRESENTED BY: The Annual Scientific Meeting Committee

This course will provide physicians with practical information designed to promote better diagnosis, rapport, treatment and motivation of people dependent on alcohol and other mood-altering chemicals.

COURSE DIRECTOR: Richard C. Bates, MD, Lansing

PRESIDING: Doctor Bates

SPEAKERS/SUBJECTS:

Richard C. Bates, MD, Internist, Lansing
"Chemical Dependency: Recognition by Preference"
Michael R. Liepman, MD, Director of Behavioral Studies, Department of Family Medicine, University of Michigan Medical School; NIAAA Career Teacher in Alcoholism and Drug Abuse, Department of Psychiatry, University of Michigan Medical School
"Gathering Historical Information and Motivating to Recovery"
Michael A. Palmen, MD, Director of Chemical Dependencies Clinic — Adult Services, Department of Psychiatry, University of Michigan Medical School
"Acute and Long-Term Management of Chemical Dependencies"

☐ Update — Scientific Writing

PRESENTED BY: Michigan Chapter, American Medical Writers Association

This course will update and review the basic principles in Scientific Writing as they pertain to the interested clinician in practice, who may wish to write medical articles for his/her hospital staff, medical newsletter, scientific journal, and/or textbook publication. Resources will be reviewed and editorial recommendations made to induce interested writers to pursue their interests, following guidelines that are consistent with present day formats. The course primarily is leveled at the neophyte investigator, regardless of background in research, teaching, and/or clinical practice. The ultimate objective is to stimulate interest in writing so that excellence may be achieved at each individual's level of competency.

COURSE DIRECTOR: Archie W. Bedell, MD, PhD, President, Michigan Chapter, American Medical Writers Association; Director of Family Practice Residency Program, Bon Secours Hospital, Grosse Pointe

PRESIDING: Doctor Bedell

SPEAKERS/SUBJECTS:

Robert J. Priest, MD, Past Officer, Michigan Chapter, American Medical Writers Association; Department of Gastroenterology, Henry Ford Hospital, Detroit
"Update — Scientific Writing"
(additional speakers to be announced)

Courses Thursday afternoon, Nov. 15

ALL COURSES RUN FROM 1:30 TO 5 P.M. WITH HALF-HOUR BREAK

☐ Changing Concepts in Evaluation and Therapy of Coronary Artery Disease

PRESENTED BY: Wayne State University School of Medicine

This course will bring the audience up to date on newer diagnostic techniques, namely nuclear cardiology and echocardiography, especially two-dimensional scanning. In addition, the course will provide experience of revascularization in the last decade. The usefulness and the limitations of exercise stress testing will be defined and the contribution of radioisotopic techniques in diagnosing coronary artery disease will be discussed.

COURSE DIRECTOR: Subhash Khullar, MD, Detroit

PRESIDING: Doctor Khullar

SPEAKERS/SUBJECTS:

Subhash Khullar, MD, Associate Professor of Medicine, Wayne State University School of Medicine and Chief of Cardiology, Detroit General Hospital
"Nuclear Cardiology"

Surjit Bhasin, MD, Assistant Professor of Medicine, Wayne State University School of Medicine
"Value and Limitations of M-Mode and Two-Dimensional Echocardiography in Coronary Artery Disease"

Doctor Khullar
"Usefulness and Limitations of EKG Stress Testing"
"Current Status of Exercise Thallium and Exercise Radioisotopic Ventricular Function Studies in Detection of Coronary Artery Disease"

☐ Current Concepts in the Medical and Surgical Management of Ischemic Heart Disease

PRESENTED BY: Michigan Chapter, American College of Chest Physicians

This course will familiarize all physicians with current problems in the diagnosis and treatment of coronary insufficiency. The course instructors are members of the clinical faculty of Wayne State University School of Medicine and are involved in the daily management of patients with this disease. Esoteric concepts will be avoided. Participants in this course, when presented with a patient with possible coronary insufficiency, should be able to outline indicated non-invasive and invasive diagnostic tests and medical, surgical or combined treatment.

COURSE DIRECTOR: Agustin Arbulu, MD, Detroit

PRESIDING: Doctor Arbulu

SPEAKERS/SUBJECTS:

Sandra M. Leitner, MD, Clinical Instructor, Department of Medicine, Wayne State University School of Medicine
"Non-Invasive Diagnosis and Treatment of Coronary Insufficiency"

Stanley B. Wolfe, MD, Clinical Assistant Professor, Department of Medicine, Wayne State University School of Medicine
"Invasive Diagnosis and Treatment of Coronary Insufficiency"

Joseph S. Bassett, MD, Clinical Assistant Professor of Surger Wayne State University School of Medicine
"Surgical Treatment of Coronary Insufficiency"

Agustin Arbulu, MD, Clinical Professor of Surgery, Wayn State University School of Medicine
"Surgical Treatment of the Bad Ventricle"

☐ Drug Therapy in Rheumatic Diseases

PRESENTED BY: Division of Rheumatology and Clinical In munology, Wayne State University School of Medicine

This course will review for the practicing physician the old an new drugs available for the management of rheumatic disease Topics to be covered are: 1) aspirin and new salicylate 2) nonsteroidal anti-inflammatory drugs; 3) corticosteroid 4) gold salts and plaquenil; 5) penicillamine; 6) immunosu pressives and experimental drugs, i.e. Levamisol.

COURSE DIRECTOR: Jose L. Granda, MD, Detroit

PRESIDING: Doctor Granda

SPEAKERS/SUBJECTS:

Felix Fernandez-Madrid, MD, Professor of Medicine, an Chief, Division of Rheumatology and Clinical Immunolog Wayne State University School of Medicine
"New Salicylate Drugs"

Samuel Indenbaum, MD, Clinical Assistant Professor, Depar ment of Internal Medicine, Wayne State University School Medicine
"Other Nonsteroidal Anti-Inflammatory Drugs (NSAID)"

Martin Atdjian, MD, Assistant Professor of Medicine, Divisic of Rheumatology and Clinical Immunology, Wayne State Un versity School of Medicine
"Plaquenil and Gold Therapy"

Jose L. Granda, MD, Associate Professor of Medicine, Divisio of Rheumatology and Clinical Immunology, Wayne State Un versity School of Medicine
"Penicillamine, Immunosuppressive and Immune Stimula Drugs"

☐ Management of Common Chest Problems

PRESENTED BY: Michigan Society of Thoracic Surgeons

This course will provide practical information about tw pediatric and two adult thoracic conditions which the famil practitioner is generally the first to see, and would wish to fo low. Signs and symptoms which would require referral to specialist are covered along with follow-up by the famil physician. Dangerous manifestations which require urgent a tention are discussed in detail. The format will consist of fo lectures by recognized experts in their respective fields, an will each be followed by a question and answer period and di cussion.

CO-COURSE DIRECTORS: Raymond J. Barrett, MD, Sout field, Secretary, Michigan Society of Thoracic Surgeons, an **Rodman E. Taber, MD,** Warren, President, Michigan Society Thoracic Surgeons

PRESIDING: Doctors Barrett and Taber

SPEAKERS/SUBJECTS:

Edward W. Green, MD, Chief of Pediatric Cardiology, Children's Hospital of Michigan, Detroit
"Management of the Infant and Child with an Asymptomatic Cardiac Murmur"
Thomas W. Shields, MD, Professor of Surgery, Northwestern University Medical School, Chicago
"Management of the Indeterminate Lung Lesion"
William Lees, MD, Clinical Professor of Surgery, Loyola University of Chicago Stritch School of Medicine, Maywood
"Management of Spontaneous and Recurrent Pneumothorax"
Arvin I. Philippart, MD, Chief of Pediatric General Surgery, Children's Hospital of Michigan, Detroit
"Management of the Newborn with Respiratory Distress"

☐ Office Diagnosis and Management of Eye Movement Disorders

PRESENTED BY: Michigan Ophthalmological Society

This course will provide practical information about the diagnosis and management of nystagmus, supranuclear eye movement disorders and extraocular muscle palsies. Physicians who complete this course will be able to recognize both common and unusual forms of these problems and develop a plan for treatments, differential diagnosis or appropriate referral.

COURSE DIRECTOR: James W. Klein, MD, Grosse Pointe Park

PRESIDING: Doctor Klein

SPEAKERS/SUBJECTS:

Frank J. Bajandas, MD, Assistant Professor, Neuro-Ophthalmology, University of Texas Health Science Center, San Antonio
"Supranuclear Eye Movement Disorders"
"Nystagmus"
Barron Klepach, MD, Assistant Professor, Neuro-Ophthalmology, Kresge Eye Institute, Detroit
"Abducens Palsy"
James W. Klein, MD, Neuro-Ophthalmologist, Detroit Institute of Ophthalmology
"Trochlear Palsy"
John W. Henderson, MD, Professor of Ophthalmology, University of Michigan Medical School
"Differential Diagnosis of Oculomotor Palsy"

☐ Ultrasonic Imaging in Clinical Radiology

PRESENTED BY: Michigan Radiological Society

Ultrasound diagnosis is now used routinely in the investigation of many diseases. In the past 5 to 10 years, there has been an enormous increase in the number of procedures performed, as well as in the number of trained physicians and instruments available. Indications and capabilities of these techniques for various organ systems will be discussed.

COURSE DIRECTOR: John N. Wolfe, MD, Clinical Professor, Department of Radiology, Hutzel Hospital, Detroit

PRESIDING: Kenneth L. Krabbenhoft, MD, Professor and Chairman, Department of Radiology, Wayne State University School of Medicine

SPEAKERS/SUBJECTS:

Paul B. Wollschlaeger, Director of Division of Neuroradiology and Diagnostic Ultrasound, Wayne State University School of Medicine; Detroit General Hospital
"Role of Ultrasound in Radiological Diagnosis"
William B. Steel, MD, Chief, Division of Diagnostic Ultrasound, Department of Radiology, Hutzel Hospital, Detroit
"Gynecological and Obstetrical Ultrasound"
Barry I. Samuels, MD, Assistant Professor, Department of Radiology, Wayne State University, School of Medicine
"Retroperitoneal Ultrasound"
Terry M. Silver, MD, Associate Professor of Radiology; Director of Section on Ultrasound, Department of Radiology, University of Michigan Medical School
"Ultrasonic Evaluation of the Right Upper Quadrant"
James J. Karo, MD, Director, Division of Diagnostic Ultrasound, Department of Nuclear Radiology, Providence Hospital, Southfield
"Echocardiography"

☐ Ventricular Premature Beats: Their Significance and Current Therapy

PRESENTED BY: Michigan Chapter, American College of Physicians

This course will cover the significance of ventricular premature beats in normal and abnormal population and the discussion of current pharmacologic intervention and new anti-arrhythmic agents. The format will consist of lecture presentations with time for discussion or questions and answers from the course participants.

COURSE DIRECTOR: Sidney Goldstein, MD, Detroit

PRESIDING: Doctor Goldstein

SPEAKERS/SUBJECTS:

Sidney Goldstein, MD, Division Head, Cardiovascular Medicine, Henry Ford Hospital, Detroit, and Clinical Professor of Medicine, University of Michigan Medical School
"Ventricular Premature Beats and Their Significance"

Melvyn Rubenfire, MD, Chief of Cardiology, Sinai Hospital, Detroit
"Invasive Evaluation of Life-Threatening Arrhythmias and a Pharmacologic Approach to Antiarrhythmic Agents"

Isaac Barr, MD, Director of Coronary Care Unit, Cardiovascular Medicine, Henry Ford Hospital, Detroit
"Use of New Antiarrhythmic Agents and Surgical Interventions in the Treatment of Life-Threatening Arrhythmias"

☐ "What's New in Treatment of Hypertension?"

PRESENTED BY: Department of Medicine, Wayne State University School of Medicine

This course will discuss newer methods of treatment for hypertension and different aspects of common treatment. Include will be discussion of non-pharmacologic therapy, controversie in the use of diuretics and a presentation on the treatment o hypertension with sympathetic agents alone.

COURSE DIRECTOR: Charles P. Lucas, MD, Detroit

PRESIDING: Doctor Lucas

SPEAKERS/SUBJECTS:

Andrew Zweifler, MD, Professor of Medicine, University Hospital, University of Michigan Medical School
"Non-pharmacologic Therapy for Hypertension"

David T. Lowenthal, MD, Hahnemann Medical College an Hospital of Philadelphia
"Controversies in the Use of Diuretics in the Treatment o Hypertension"

Charles P. Lucas, MD, Professor of Internal Medicine, Wayn State University School of Medicine
"Treatment of Hypertension with Sympathetic Agent Alone"

This course is supported in part by a financial grant fron Boehringer-Ingelheim Ltd.

Special events planned Nov. 13-14-15

Michigan Family Practice Clubs: Tuesday, November 13; reception and dinner

Michigan Ophthalmological Society: Thursday, November 15; 9 am business meeting, evening reception and dinner

Michigan Orthopaedic Society: Tuesday, November 13; morning business meeting and luncheon and evening reception/dinner

Michigan Otolaryngological Society: Wednesday, November 14; reception and dinner

Michigan Psychiatric Society: Thursday, November 15; 8 am Council meeting, evening reception and dinner

Michigan Radiological Society: Thursday, November 15; reception and dinner

Michigan Society of Colon and Rectal Surgeons: Wednesday, November 14; reception and dinner

Michigan Society of General Surgeons: Wednesday, November 14; business meeting and dinner

Michigan Society of Neurological Surgeons: Tuesday, November 13; reception and dinner

Michigan Society of Obstetricians and Gynecologists: Wednesday, November 14; 1 pm business meeting

Michigan Urological Society: Wednesday, November 14; reception and dinner

Wayne State University Alumni: Wednesday, November 14; reception

PLEASE SEND ENTIRE PAGE WITH CHECK

1979 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration Form for Category I CME Courses

* Courses Approved for Prescribed Credit by the American Academy of Family Physicians

TUESDAY MORNING, NOV. 13

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Overview of Pulmonary Diseases in Children, Adults and Elderly Patients
*_____ Cancer Prevention: Practical Medicine for the Family Physician
*_____ Diabetes — The State of the Art (Part I)
*_____ Hematology for Non-Hematologists
*_____ Industrial and Environmental Pollutants
*_____ New Concepts in Evaluation and Treatment of Stroke Syndrome
*_____ Preventing Physician Suicide Through Early Recognition and Proper Care
*_____ What's New in Office Gynecology

TUESDAY AFTERNOON, NOV. 13

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Birth and Death of the Endocrine System
*_____ Basic Life Support
*_____ Common Errors in ECG Interpretations
*_____ Diabetes — The State of the Art (Part II)
*_____ Gastrointestinal and Pulmonary Endoscopy: A Review
*_____ Management of Chronic Low Back Pain
*_____ Neurological Problems for the Primary Physician
*_____ Practical Approach to Electrolyte Problems
*_____ Sports Medicine for Primary Care Physicians
*_____ The Use of CAT-Scan in Making a Diagnosis Economically
*_____ Use of Psychoanalytic Knowledge in Medical Practice

The half-day courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice should the first choice already be filled.* Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, luncheon tickets, etc., must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/20/79 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

WEDNESDAY MORNING, NOV. 14

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Advanced Cardiac Life Support (A 16-hour course to run all-day Nov. 14 and 15. See tuition below.)
*_____ Alpha-Omega Session: Urinary Tract Infection in Children and Adults
*_____ Diagnosis and Treatment of Chronic Ear Disease for Primary Care Physicians
*_____ Management of Gastrointestinal Bleeding
*_____ Management of Premalignant Breast Disease
*_____ Mechanical Ventilation in Acute Respiratory Failure — Newer Techniques
*_____ Office Dermatology for the Non-Dermatologist
*_____ Pediatric and Adolescent Gynecology
*_____ Physician Role in Cost-Effective Medical Care
*_____ Stresses Within the Physician's Family
*_____ What's New in Allergy and Asthma in Children
*_____ What's New in Antibiotics and Common Office Infections

WEDNESDAY AFTERNOON, NOV. 14

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Hematuria
*_____ Bronchial Asthma in Adults: Diagnosis and Management
*_____ Cutaneous Manifestations of Systemic Disease — Lupus Erythematosus
*_____ Doctor, Why Did You Cancel My Case?
*_____ Inflammatory Bowel Disease
*_____ Nuclear Medicine — Its Practical Value
_____ Otolaryngological Diseases: Latest Advances in Technique and Management
*_____ Psychology of Abortion
*_____ Reconstruction Following Mastectomy
*_____ What's New in Common Pediatric Problems
*_____ What's New in Evaluation of the Dizzy Patient

THURSDAY MORNING, NOV. 15

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Diagnosis and Management of Monoarticular Arthritis
*_____ Ethical Issues in Medicine
*_____ New Concepts in Congestive Heart Failure
*_____ Ophthalmology's Role in Medicine
*_____ Preventive Cardiology — The Primary Care Mission
*_____ Understanding and Treating Alcoholism and Drug Dependence
*_____ Update in Scientific Writing

THURSDAY AFTERNOON, NOV. 15

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Changing Concepts in Evaluation and Therapy of Coronary Artery Disease
*_____ Current Concepts in the Medical and Surgical Management of Ischemic Heart Disease
*_____ Drug Therapy in Rheumatic Diseases
*_____ Management of Common Chest Problems
*_____ Office Diagnosis and Management of Eye Movement Disorders
*_____ Ultrasonic Imaging in Clinical Radiology
*_____ Ventricular Premature Beats: Their Significance and Current Therapy
*_____ What's New in Treatment of Hypertension

Name (please print) ______________________________
(first) (initial) (last)

Street ______________________________

City, State ______________________________ Zip ____________

Please fill in: MSMS Member: Yes ____ No ____ Resident ____ Specialty ____________

Tuition schedule for courses:
MSMS members: $4 per credit hour, or $12 for each half-day course
Non-members: $8 per credit hour, or $24 for each half-day course
Residents: No charge

Luncheon reservations: The hotel will provide luncheon each noon at $8 per person. Advance reservations are requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

Tuesday lunch ______ Wednesday lunch ______ Thursday lunch ______

- Indicate total number of half-day courses ____ × $12 (or $24) = $ ______
- Number of luncheons requested ____ × $8 = $ ______
- Registration for special 16-hr ACLS Course ($150 incl. lunch) $ ______
- Total amount due MSMS $ ______

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

Special Advanced CLS course offered Nov. 14-15

For the second year in a row, The MSMS Annual Scientific Meeting will include a special two-day course in the nationa[illegible]gnized Advanced Cardiac [illegible]port training and certification[illegible]

The course, pl[illegible]Wednesday and Thursday, No[illegible]d 15, will award 16 Category [illegible]credit hours. In addition, candidates who successfully complete the testing according to American Hospital Association standards will be certified as providers in ACLS by the Michigan Heart Association.

The Michigan chapter, American College of Emergency Physicians, is presenting the course, which runs eight hours each day. Course directors are Ann L. Harwood, MD, Butterworth Hospital, Grand Rapids, and Eugene C. Grochowski, MD, PhD, Bronson Methodist Hospital, Kalamazoo.

The course will be limited to 48 physicians who have completed the basic CLS course. A three-hour Basic Life Support course will be offered Tuesday afternoon, Nov. 13 for anyone who might then want to go on to the advanced course on Wednesday and Thursday.

Physicians must register for the ACLS course before Oct. 1. They will be sent an extensive packet of study materials and instructions. The American Heart Association CLS texts will be followed.

Interested physicians should use the registration form on page 19 of this issue to make arrangements to attend this course. A fee will be charged to cover costs of study materials, and for a special trained faculty.

The course consists of lecture material and new concepts in training and testing for the practical skills of ACLS.

Lectures will deal with adjuncts for airway and ventilation, circulation, monitoring and dysrhythmia recognition, defibrillation and synchronized cardioversion and establishment of IVs. Eight stations will be used to train the participants in ACLS skills.

Select courses of practical value:

Enroll today . . . take your choice . . .

8 courses, Tuesday morning, Nov. 13 — See pages 2 and 3.

11 courses, Tuesday afternoon, Nov. 13 — See pages 4, 5 and 6.

12 courses, Wednesday morning, Nov. 14 — See pages 7, 8, 9 and 10.

11 courses, Wednesday afternoon, Nov. 14 — See pages 11, 12 and 13.

7 courses, Thursday morning, Nov. 15 — See pages 14 and 15.

8 courses, Thursday afternoon, Nov. 15 — See pages 16, 17 and 18.

For registration form – see page 19

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 78 No. 25, September 7, 1979

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Editor: Judith Marr

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Annual Scientific Meeting
Registration form on page 470 inside

Michigan Medicine

EPTEMBER 1979 • VOLUME 78, NUMBER 26
OURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

SCIENTIFIC MEETING

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Contents

September 1979, Vol. 78, Number 26

Michigan Medicine

Special Section

463 The 1979 MSMS Annual Scientific Meeting is scheduled Nov. 13-14-15. Michigan physicians will find all they need to know about courses, faculty, hotel, attractions of the area, as well as a registration form, in this month's special section.

Features

484 **The MSMS view of the FTC Complaint filed against MSMS late in July**; Mert Scholten

495 **The Statewide Health Manpower Survey**

500 **Legislative profile: Edward C. Pierce, MD, Michigan's only MD-legislator**; Willah Weddon

507 **Desk Reference Card on Status Epilepticus**

Departments

472 **President's page**; Ernest P. Griffin Jr., MD

474 **Committees: Liaison with Board of Medicine**; Katie Brewbaker

476 **Views: The impaired physician**; Richard C. Bates, MD; Robert D. Burton, MD; Donald E. DeWitt, MD; Gerald H. Mandell, MD; Douglas A. Sargent, MD, and Paul T. Werner, MD; **also hospital EMS categorization**; John G. Wiegenstein, MD

489 **Letters**

490 **MSMS/A**; Mildred F. Carron

492 **Medico-legal**

494 **News**; Katie Brewbaker

496 **New feature: Health planning update**; Dennis Paradis

499 **Business: Finance charges**; R. Timothy Hogan, CPBC

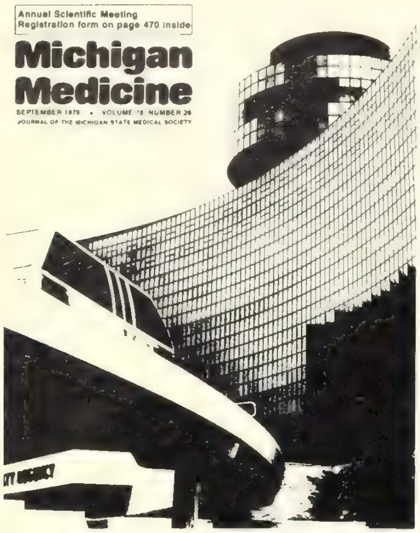
505 **Meetings**

514 **Category I courses**

522 **Deaths**

524 **Classified Ads**

525 **Ad index**


Annual Scientific Meeting
Registration form on page 470 inside
Michigan Medicine
SEPTEMBER 1979 • VOLUME 78 NUMBER 26
JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

The expanded and improved Hyatt Regency Dearborn, with its elevated people mover skimming to and from the Fairlane Center shopping mall, is the site of the 1979 MSMS Annual Scientific Meeting. Details and registration blank appear on pages 463-470 of this issue. (Photo by Mert Scholten)

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society.

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MSMS Annual Scientific Meeting Nov. 13-15 a must on physicians' CME calendars

"The MSMS Annual Scientific Meeting this year will cover many topics which should interest almost anyone involved in almost any specialty of medicine." So says Samuel M. McMahon, MD, Chairman 1979 MSMS Annual Scientific Meeting.

"The meeting this year will differ from previous years in that there will be a greater emphasis on a "hands on" and participatory experience.

"For example, opportunities will be available to read EKG's, see and handle endoscopy equipment, and perform certain aspects of specialized examinations of the ear, the eyes, and the neurological system.

All programs will be relevant to clinical practice and most will have various handout materials which can be taken away for additional study by physicians attending courses, stresses Doctor McMahon.

"I think this year's courses will be outstanding in many respects and will be much more realistic and helpful than courses which many comparably-sized state medical societies provide," says Doctor McMahon.

"In addition to providing a good educational update and summary of the subjects chosen, this will represent nearly the last opportunity available this year for rounding out the required Category I courses for relicensure in Michigan."

The MSMS Annual Scientific Meeting is one of the largest state medical society educational meetings in the United States.

The three-day format includes a two-day Advanced Cardiac Life Support course awarding certification and 16 hours of Category I credit, and 56 half-day courses in a wide range of medical subjects for three credits each.

Approximately 250 distinguished faculty members from throughout Michigan, several states and even foreign countries will present their subjects through a variety of teaching methods.

Doctor McMahon and his committee have broadened the scope of presentations this year to include "wet clinics" in which patients will be present, demonstrations will be made using live models and participants will take part in hands-on sessions.

Among these live demonstrations will be group discussions of ECGs, and how-to sessions on athletic taping and use of the latest endoscopic equipment and techniques.

Doctor McMahon also is encouraging an "alpha-omega" approach, instructing as many faculty members as possible to describe the disease or treatment of their expertise as it affects persons of all ages.

Alpha-omega courses are planned on diabetes, the endocrine system, urinary tract infections, hematuria and the respiratory system.

Doctor McMahon and his committee have been meeting for a year to plan the new and exciting features of this 1979 meeting.

Nearly every major medical specialty society plans courses at the Annual Scientific Meeting. Doctor McMahon has encouraged their participation and they have responded extremely well.

In many cases, the specialty will have a full day of courses. At the same time, the courses are being planned with the family physician in mind, and the American Academy of Family Physicians will award prescribed credit for all but one of the courses.

Most of the MSMS staff, led by Coordinator of CME programs Sherry Fent, will be enlisted to serve during the three days of registration, ticket sales, room arrangements and set-up and as course assistants.

Staff members will be on hand to greet and guide MSMS members about the meetings and exhibits areas and to answer questions about MSMS services and activities in the large exhibits hall.

Physicians are urged to register early, as courses are expected to fill early, as they have the past few years. It is particularly important to register early for the Advanced Cardiac Life Support course, which has a limited enrollment.

Registration forms for all courses are printed in the first September *Medigram* and this issue of *Michigan Medicine* (see page 470) so that physicians will have adequate time to plan their calendars.

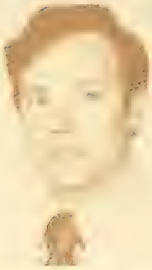
Those needing sleeping room reservations are urged to contact the Hyatt Regency early and let the reservation clerk know they are part of the MSMS conference, to take advantage of the special room rate. Room reservations should be made directly before Oct. 20, by calling the Hyatt at 313/593-1234.

Please check each of the eight special pages in this issue for up-to-date information on the 1979 MSMS Annual Scientific Meeting Nov. 13-14-15 at the Hyatt Regency Dearborn. You'll find the meeting reservation form, a photo gallery of directors for the 56 half-day courses, feature stories on the hotel, cultural events planned in the Detroit area at the time of the meeting and local attractions, and a list of exhibitors.

Samuel M. McMahon, MD
Scientific Meeting
Chairman

Meet the directors for half-day courses at Scientific Meeting

Alexander



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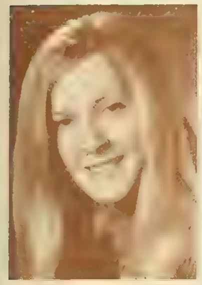
See Scientific Meeting Registration form on page 470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Peppard

Potchen

Rontal

Rovner

Royer

Sargent

Smith

Sparrow

Taber

Tourkow

Weg

Willis

Wolfe

Exciting attractions abound at meeting site

By Shelton Reece
Special to **Michigan Medicine**

Though your schedule will be crowded with classes during the MSMS Annual Scientific Meeting, you, Doctor, and your spouse probably will want to take time to sample at least a few of the exciting attractions in the Dearborn area.

Dearborn is one of this country's most unique vacation spots, with Greenfield Village and the Henry Ford Museum — celebrating their 50th anniversaries this year — perhaps the best known.

The Village and Museum are close by the Hyatt Regency Dearborn, itself a beautiful luxury vacation facility.

Next door is the ultra-modern Fairlane shopping center, a gigantic, climate-controlled mall (with more than 180 shops and services) connected to the hotel by an elevated Automatically Controlled Transportation System ("people mover").

Once in the stunning, crescent shaped, 800-room hotel, you are surrounded by beauty and excellent service. The first floor houses unusual sculptures and paintings, a spectacular 125-foot chandelier, and is the base of the 14-story atrium and tiered guest levels (floors on which guest rooms are located). Dozens of live plants hang from each tier, creating the impression of a large formal garden.

The rooms and suites are tastefully decorated in warm earth tones and each offers an unobstructed view of the surrounding area.

Getting to and from your room at the Hyatt Regency Dearborn is exciting, as you take glass-enclosed capsule-like elevators and enjoy a panorama of the hotel during your ride.

The Hyatt Regency Dearborn, with helicopter pad in front.

Restaurants and lounges

For cocktails and dining, the Regency cannot be topped in Michigan.

The Lobbi Bar on the first level serves cocktails from 10 AM until midnight, with a pianist on hand Tuesday through Saturday nights; Kafay's Place serves contemporary cuisine for breakfast, lunch and dinner from 6:30 AM until 1 AM; the Rotunda, located on the 16th floor, is a revolving rooftop restaurant which serves lunch from 11 AM until 3 PM daily, and cocktails from 11 AM until 2 AM; La Rotisserie, the hotel's gourmet restaurant serves dinner from 6 to 11 PM, Monday through Saturday.

Le Prelude, an intimate lounge adjacent to La Rotisserie, is open from 11 AM to 2 AM, Monday through Saturday, and until 1 AM Sunday; Giulio & Sons serves lunch Monday through Saturday from 11 AM until 2:45 PM and dinner daily from 6 until 10:45 PM; db's Club, a showcase for well-known entertainers, offers two shows per evening, Tuesday through Saturday; and the Splish-Splash, a poolside snack bar, serves sandwiches, snacks, and cocktails from 11:30 AM to 5:30 PM daily.

Other recreational facilities at the Regency include an indoor, heated, 32-foot in diameter circular swimming pool, a whirlpool for complete relaxation, and an Arizona dry-heat sauna. The pool area also has locker rooms, towels, showers, hair dryers and toiletry amenities for your use at a nominal charge.

While you are a guest at the hotel you also can enjoy nearby Fairlane Manor, which offers indoor and outdoor swimming, tennis, racquet ball and handball courts, bowling, billiards, plus men's and women's exercise rooms.

And when you feel like shopping, just step onto the ACT for the minute and one-half ride to Fairlane Mall where stores such as Lord and Taylor, J. L. Hudson, Sears, J. C. Penney, and approximately 160 fashion and specialty shops plus five movie theaters are housed in terraced courts adorned with unusual art objects. The Center also includes 14 restaurants, a regulation-size, year-round ice arena, and its own waterfall.

Village and Museum

When you have a bit more free time, you will probably want to travel the few miles necessary to visit, or re-visit The Edison Institute, popularly known as Greenfield Village and the Henry Ford Museum.

The Village and Museum have become the nation's most visited private historical collections and are continuing to grow in stature as centers for the study and enjoyment of Americana. The 260-acre complex was created 50 years ago by auto pioneer Henry Ford to preserve for future generations the interesting and important objects that were part of the lives of the people who built America. Since its beginning, the complex has grown steadily and has attracted more than 40,000,000 visitors.

The Village began with 27 historic buildings and today has more than 100. The Museum now has 14 acres of exhibits — fronted by replicas of Philadelphia's Independence, City and Congress Halls — including comprehensive collections of decorative and home arts, lighting and communications devices, land and air transportation vehicles, agricultural and shop machinery.

Crafts demonstrations

In addition to viewing the many exhibits while at the Village and Museum, you can see demonstrations of the following crafts: baking, blacksmithing, broom making, candle production, glass blowing, leatherworking, pewter work, pottery making, silversmithing, printing, spinning and carding, tinsmithing, weaving, wrought ironwork, and power loom weaving. Rides at the Village are provided by carriages, the Suwanee Steamboat, Model T automobiles, a steam train, and in the winter, by sleighs. Separate admissions are charged to the Village and to the Museum. They are $3.75 for adults, and $1.75 for children 6 through 12 years old. Children under six are admitted free. People over 65-years-of-age are charged $3 at both the Village and at the Museum. Group rates are available.

If your visit to the complex is near meal time, you may want to eat at the Riverfront Restaurant, Clinton Inn, The Feedbag, or Pound 'n' Coop at the Village, or at Heritage Hall which is accessible to visitors at both the Village and Museum. Or, if you would like to dine at the country's oldest airport hotel, The Dearborn Inn is one mile away. The Inn was built in 1931 for travelers who landed at Ford Airport and today offers cocktails and delicious food at its coffee shop and dining room.

The Hyatt Regency Dearborn will offer MSMS members and spouses a discount rate for rooms if they register by Oct. 20. Physicians should reserve rooms direct, mentioning their attendance at the MSMS meeting. Write Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, 48126.

Specialties plan activities during Annual Scientific Meeting

Arrangements are well underway for 13 specialty society meetings and related activities during the annual MSMS Scientific Meeting Nov. 13-14-15 at the Hyatt Regency Dearborn.

Several of the specialty societies are holding luncheons, dinners, or receptions at some time during the three days.

One of the largest of these gatherings will be the annual Family Practice Clubs dinner on Tuesday night, Nov. 13, hosted by the Michigan Academy of Family Physicians. This event is expected to draw upwards of 400 medical students from the three medical schools in Michigan. The exhibits will be open during the MSMS-hosted reception prior to the dinner.

Family physicians are invited to attend this reception and dinner to talk with the students who are potential family practitioners. A keynote speaker is being invited to talk to the group about family practice. Members of the MAFP will be sent further details in a special mailing and should make their reservations directly with the Academy as there will be no tickets available at the door.

Other groups holding special meal functions or receptions include the Michigan Orthopaedic Society, the Michigan Society of Neurological Surgeons, the Michigan Society of Obstetricians and Gynecologists, the Michigan Otolaryngological Society, the Michigan Urological Society, the Michigan Society of Colon and Rectal Surgeons and the Michigan Society of General Surgeons.

Also hosting business meetings, receptions or dinners will be the Michigan Psychiatric Society, the Michigan Ophthalmological Society and the Michigan Radiological Society.

The Wayne State University Alumni will be holding a reception on Wednesday, Nov. 14.

Physicians interested in any of these special events should contact their respective specialty societies for details.

CME Programming Committee Chairman Carl F. Hammerstrom, MD, right, visits booth of 1978 MSMS Scientific Meeting exhibitor Morton Hack of the Hack Shoe Company.

75 educational exhibits are a convention feature

Some 75 commercial exhibitors have reserved space at the 1979 Annual Scientific Meeting to display the latest in pharmaceuticals, office systems, computers, collection services, insurance, phone equipment, car leasing and educational materials.

In addition, a number of allied organizations and services will use exhibit space to answer questions and dispense information on a host of their programs, materials and services. Among these will be the Michigan Health Council, the Michigan Board of Medicine, and the MSMS Physician Service Group, Inc.

The American Medical Association-Education Research Foundation will have a boutique-booth offering a variety of gift items. All proceeds from these sales will go to ERF which in turn, provides annual funding grants to the three medical schools in Michigan.

Daily "beer busts" will be held in the exhibit area from 4:30-5:30 p.m. where attendees can enjoy a bit of refreshment while viewing the variety of exhibits. Twice-a-day coffee breaks will be held in the exhibit area as well.

A buffet luncheon will be available each noon for the convenience of physicians attending the daily scientific sessions.

Several of the exhibitors will host hospitality suites during the meeting. These suites will be open by invitation only through the company personnel working the exhibits.

Here is a list of the exhibitors for the Annual Scientific Meeting:

Advance Medical & Research, Inc.
American Massage Chair Company
Ames Division, Miles Laboratories
Ayerst Laboratories
Blue Cross Blue Shield of Michigan
Boehringer Ingelheim, Ltd.
CIBA Pharmaceutical Company
City X-Ray Company
Continental Bio-Clinical Lab.
Ted Cyman Distributors
Data-Med Corporation
Datapro
Data Sense, Inc.
Dearborn Clinical Laboratory
Dempsey Data Service
Dow Chemical USA
E & M Medical Systems, Inc.
Encyclopaedia Britannica
Ferndale Laboratories
Firestone X-Ray Corporation
Geigy Pharmaceuticals
Gerber Products Company
Grolier Interstate
Healthways, Inc.
Hoechst-Roussel Pharmaceuticals
International Medical Electronics
Laboratory Procedures, Inc.
Laboratory Science, Ltd.
Lederle Laboratories
Eli Lilly and Company
McCullagh Leasing, Inc.
McNeil Laboratories
Mead Johnson Nutritional Div.
Mead Johnson Pharmaceutical Div.
Medical Plastics Laboratory, Inc.
The Medical Protective Company
Merck Sharp & Dohme
Metpath, Inc.
Metropolitan X-Ray Sales
Michigan Army National Guard
Michigan Bell Telephone Co.
Michigan Board of Medicine
Michigan Education Special Services
Michigan Health Council
Michigan Physician's Mutual Liab.
MSMS Physician Service Group
Mid-Michigan X-Ray Company
Milex of Michigan
N.B.A. Clinical Laboratories
National Health Laboratories
National Medical Enterprises
Niagara of Detroit
North American Pharmacal
Para Data of Michigan
Parke-Davis
Parliament Leasing Corp.
Pro Med, Inc.
Purdue Frederick Company
Reed & Carnrick
Rollins Medical/Dental Systems
Sandoz Pharmaceuticals
W. B. Saunders
Schering Corporation
Smith Kline & French Laboratories
Statewide Electronics
Stratton-Cheeseman & Assoc., Inc.
Stuart Pharmaceuticals
Systemedics Associates
Tele-Com Office Products, Inc.
Troy Biologicals, Inc.
U. S. Air Force
U. S. Army
U. S. Navy
The Upjohn Company
Welcor, Inc.

Speakers for Annual Scientific Meeting come from 20 states, plus Michigan

Bloch

Gregerman

Lees

Shields

Physicians attending the 1979 MSMS Annual Scientific Meeting will find a host of outstanding instructors to suit their tastes.

By the opening date of Nov. 13, upwards of 20 states plus Michigan will be represented as course directors finalize arrangements with recognized experts in their respective medical fields.

Among the confirmed speakers are Anthony Furlan, MD, of the Cleveland Clinic Department of Neurology, scheduled to speak on "Non-Invasive Tests in the Diagnosis of Stroke," and "Vertebral Basilar Insufficiency-Diagnosis and Management."

Thomas E. Bittker, MD, Phoenix, chairman of the Division of Psychiatric Education of the Arizona Health Plan, will speak on "Preventing Physician Suicide" as part of a course organized by the MSMS Committee to Assist Impaired Physicians and the Michigan Psychiatric Society Committee on the Well-Being of Physicians.

"Supranuclear Eye Movement Disorders" and "Nystagmus" are topics being presented by Frank J. Bajandas, MD, Assistant Professor of Neuro-Ophthalmology at the University of Texas Health Science Center in San Antonio.

Maryland will be represented by Robert I. Gregerman, MD, who is with the National Institutes of Health, Gerontology Research Center in Baltimore. He is speaking on the "Relationship Between Aging and Changes in Function of the Endocrine System" as part of the Alpha-Omega Session entitled "Birth and Death of the Endocrine System."

Steven J. Engelberg, MD, from the University of Washington School of Medicine's Department of Psychiatry, Division of Child Psychiatry, will deal with "Pediatric and Adolescent Gynecologic Psychiatry."

Internists, gastroenterologists, general surgeons and colon and rectal surgeons will be interested to hear Victor W. Fazio, MD, of the Cleveland Clinic discuss "Surgical Treatment of Crohn's Disease" as part of the total presentation on Inflammatory Bowel Disease.

One of the topics bound to attract attention is the "Psychology of Abortion" course which will feature Dorothy Bloch, MD, of the National Psychological Association for Psychoanalysis and author of *So The Witch Won't Eat Me.*

Another of the non-Michigan speakers will be Laurence F. Greene, MD, PhD, professor of clinical surgery/urology from the University of California School of Medicine in San Diego, who will present "Hematuria — An Overview" as a wrap-up to an Alpha-Omega Session.

Robert C. Ellison, MD, director of the Division of Preventive Cardiology at Children's Hospital Medical Center in Boston will be a featured presentor at the Thursday morning session on "Preventive Cardiology — The Primary Care Mission" being presented by the MSU College of Human Medicine's Department of Human Development.

Two Chicago medical schools are being represented in a Thursday afternoon course on Management of Common Chest Problems. Thomas W. Shields, MD, professor of surgery at Northwestern University Medical School will speak on "Management of the Indeterminate Lung Lesion," while William Lees, MD, clinical professor of surgery at Loyola University's Stritch School of Medicine will present "Management of Spontaneous and Recurrent Pneumothorax."

The Hyatt Regency Dearborn atrium.

PLEASE SEND ENTIRE
PAGE WITH CHECK

1979 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn
Registration Form for Category I CME Courses

* Courses Approved for Prescribed Credit by the American Academy of Family Physicians

TUESDAY MORNING, NOV. 13

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Overview of Pulmonary Diseases in Children, Adults and Elderly Patients
*_____ Cancer Prevention: Practical Medicine for the Family Physician
*_____ Diabetes — The State of the Art (Part I)
*_____ Hematology for Non-Hematologists
*_____ Industrial and Environmental Pollutants
*_____ New Concepts in Evaluation and Treatment of Stroke Syndrome
*_____ Preventing Physician Suicide Through Early Recognition and Proper Care
*_____ What's New in Office Gynecology

TUESDAY AFTERNOON, NOV. 13

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Birth and Death of the Endocrine System
*_____ Basic Life Support
*_____ Common Errors in ECG Interpretations
*_____ Diabetes — The State of the Art (Part II)
*_____ Gastrointestinal and Pulmonary Endoscopy: A Review
*_____ Management of Chronic Low Back Pain
*_____ Neurological Problems for the Primary Physician
*_____ Practical Approach to Electrolyte Problems
*_____ Sports Medicine for Primary Care Physicians
*_____ The Use of CAT-Scan in Making a Diagnosis Economically
*_____ Use of Psychoanalytic Knowledge in Medical Practice

The half-day courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice should the first choice already be filled.* Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, luncheon tickets, etc., must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/20/79 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

WEDNESDAY MORNING, NOV. 14

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Advanced Cardiac Life Support (A 16-hour course to run all-day Nov. 14 and 15. See tuition below.)
*_____ Alpha-Omega Session: Urinary Tract Infection in Children and Adults
*_____ Diagnosis and Treatment of Chronic Ear Disease for Primary Care Physicians
*_____ Management of Gastrointestinal Bleeding
*_____ Management of Premalignant Breast Disease
*_____ Mechanical Ventilation in Acute Respiratory Failure — Newer Techniques
*_____ Office Dermatology for the Non-Dermatologist
*_____ Pediatric and Adolescent Gynecology
*_____ Physician Role in Cost-Effective Medical Care
*_____ Stresses Within the Physician's Family
*_____ What's New in Allergy and Asthma in Children
*_____ What's New in Antibiotics and Common Office Infections

WEDNESDAY AFTERNOON, NOV. 14

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Hematuria
*_____ Bronchial Asthma in Adults: Diagnosis and Management
*_____ Cutaneous Manifestations of Systemic Disease — Lupus Erythematosus
*_____ Doctor, Why Did You Cancel My Case?
*_____ Inflammatory Bowel Disease
*_____ Nuclear Medicine — Its Practical Value
_____ Otolaryngological Diseases: Latest Advances in Technique and Management
*_____ Psychology of Abortion
*_____ Reconstruction Following Mastectomy
*_____ What's New in Common Pediatric Problems
*_____ What's New in Evaluation of the Dizzy Patient

THURSDAY MORNING, NOV. 15

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Diagnosis and Management of Monoarticular Arthritis
*_____ Ethical Issues in Medicine
*_____ New Concepts in Congestive Heart Failure
*_____ Ophthalmology's Role in Medicine
*_____ Preventive Cardiology — The Primary Care Missi
*_____ Understanding and Treating Alcoholism and Di Dependence
*_____ Update in Scientific Writing

THURSDAY AFTERNOON, NOV. 15

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Changing Concepts in Evaluation and Therapy Coronary Artery Disease
*_____ Current Concepts in the Medical and Surgical Management of Ischemic Heart Disease
*_____ Drug Therapy in Rheumatic Diseases
*_____ Management of Common Chest Problems
*_____ Office Diagnosis and Management of Eye Movement Disorders
*_____ Ultrasonic Imaging in Clinical Radiology
*_____ Ventricular Premature Beats: Their Significance Current Therapy
*_____ What's New in Treatment of Hypertension

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City, State __________ Zip __________

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Tuition schedule for courses:
MSMS members: $4 per credit hour, or $12 for each half-day course
Non-members: $8 per credit hour, or $24 for each half-day course
Residents: No charge

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Tuesday lunch _____ Wednesday lunch _____ Thursday lunch _____

- Indicate total number of half-day courses _____ × $12 (or $24) = $ _____
- Number of luncheons requested _____ × $8 = $ _____
- Registration for special 16-hr ACLS Course ($150 incl. lunch) $ _____
- Total amount due MSMS $ _____

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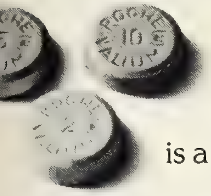
A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® Ⓘⓥ

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

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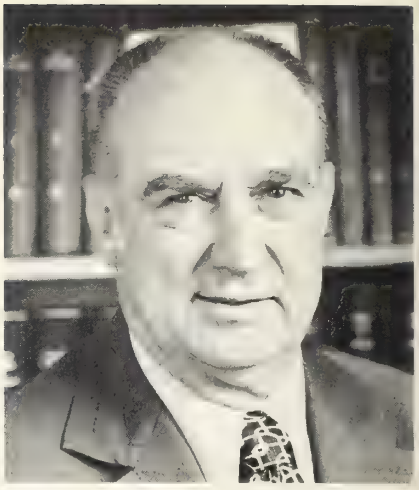
President's page

Here are three important ways MDs can cut hospital costs



Ernest P. Griffin, Jr., MD
MSMS President

Let me give you my ideas on how we can control the cost of medical care in hospitals. This cost is incurred after access has been gained to the medical system, of course.

This article is the final part of several excerpted from the address I presented to the 1979 MSMS House of Delegates. The June, July and August president's pages have carried the earlier portions.

How can hospital costs be controlled?

- Through the resident medical staff.

In general, today, they are not under control. They are not responsible for an explanation of why a particular procedure was ordered. They are never required to explain their activities to the attendings. The attendings, either for lack of interest or by design, can assign the care to the resident staff. Attendings make no effort to demonstrate to the resident staff how these activities contribute to the cost of medical care.

- Through the attending staff.

Physicians should make use of the program developed by our own MSMS Task Force on Medical Care Costs. Briefly; we should learn hospital costs and use every opportunity to decrease them.

We should teach cost awareness to the resident staff.

We should limit diagnostic testing to indicated tests and thereby promote efficiency.

We should reduce hospital utilization. Many diagnostic work-ups can be accomplished on an outpatient basis at reduced costs.

- Through diagnostic methods.

Concerning cost containment as it applies to diagnosis: I can hear the hue and cry now about cookbook medicine, but I say that it is where we can put our scientific knowledge to work and make our greatest impact on the cost of medical care.

Fortunately, there are institutions in this country such as the University of California at San Francisco that are making a scientific study of the use of procedures that lead to a precise diagnosis in the shortest time at the least cost.

The term algorithm has been applied; we should develop such an approach. Given a problem, we would immediately use the test that is most likely to produce the diagnosis.

For instance, let us talk about obstructive jaundice. The two tests that consistently yield the greatest number of diagnoses immediately are the CT scan and the trans-hepatic needle cholangiogram. If available, these should be used first at a cost of approximately $600, as against all the tests that might result in a diagnosis and cost $3,000. If we develop such a system for all problems, we could save an untold number of dollars.

We must develop plan to attack and solve costs

My charge to my fellow MSMS members is that we had better forget all contracts for medical care that only control the physician's fee, and other similar physician-oriented limitation devices, and develop a comprehensive plan that will attack and solve the problem.

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg

(1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

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Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
Before prescribing, see package insert for full product information.

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Board of Medicine Liaison Committee has full agenda

At the recent joint meeting of the MSMS Board of Medicine Liaison Committee with the board, committee chairman Charles L. Seifert, MD, Battle Creek, left, met with board president John N. Wilson, MD, Grand Rapids.

By Katie Brewbaker
MSMS staff

The Administrative Rules of the new Public Health Code, triennial re-licensure of physicians, emergence of physician assistants, search for physician peer review consultants — these are some of the recent concerns that have demanded the attention of the MSMS Liaison Committee with the Board of Medicine.

Of special concern to MSMS and the Board were two administrative rules which, as originally interpreted, restricted the involvement of the Board of Medicine in disciplinary hearings of physicians.

MSMS, as well as the Board of Medicine, testified to the urgency of permitting the Board to participate in hearings whenever medical-technical knowledge is required. As a result of this action, the Department of Licensing and Regulation has re-drafted the rules to provide greater Board of Medicine input.

MSMS has been working with the Board on a proposal for triennial re-licensure which would provide that approximately one-third of the physicians in Michigan would have to re-register annually. Not only would this prove more convenient for physicians, it would allow the Board of Medicine to make more efficient use of its administrative offices in the implementation of the re-licensure procedure.

There are over 500 physician assistants in Michigan, many of which already are employed by physicians. However, rules have not yet been promulgated to clearly establish what procedures they may perform under the supervision of a physician, nor has an outline of the standards of the physician assistants training program been provided.

The Board of Medicine is seeking the advice of MSMS on the content of the rules so they will reflect, realistically, how a physician assistant can best be part of the health team within the scope of his/her qualifications.

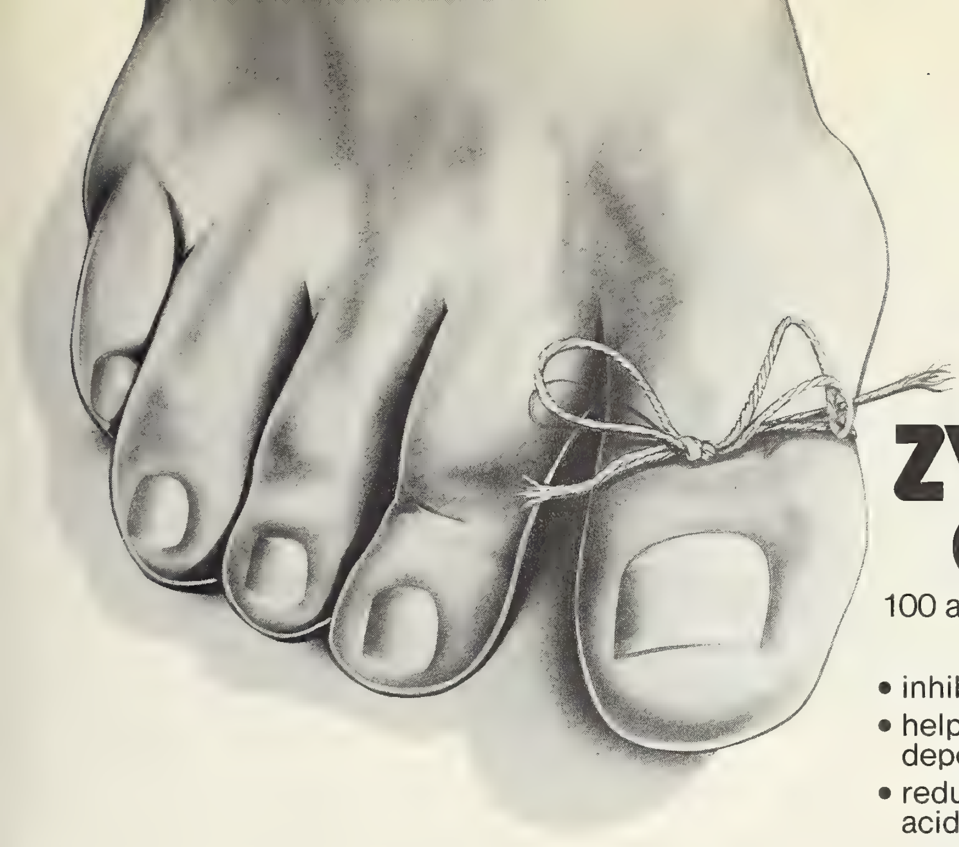
The Board expressed an urgent need for physicians who will serve as consultants in peer review cases. The Liaison Committee responded by submitting a recommendation to The Council that a list of specialists willing to assist the Board be developed and updated annually.

These and other issues have been discussed at a series of joint meetings between the Liaison Committee and the full membership of the Board of Medicine. Much work remains, and the two bodies are assured of full agendas at their future sessions.

Corrections:

In the August issue of *Michigan Medicine*, winning photos in the first MSMS contest for members and guests on the MSMS travel tours were published. Photographer for the entry "Priest," second place color category, is C. F. Webb, MD, Grand Rapids, rather than Kathryn Bauer of Lathrop Village.

Also in the August issue, the location of the Sept. 29-30 Burns Clinic/Northern Michigan Hospitals Annual Medical Meeting should have been the Holiday Inn, Petoskey, and the address of the contact person at Northern Michigan Hospitals, Petoskey.



A reminder

ZYLOPRIM®

(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

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Views

The impaired physician: Michigan MDs comment on the problem, suggest solutions

In the following series of comments, Michigan physicians discuss the impaired physician — the appropriateness of MSMS concern with finding and helping such physicians, whether enough has been done to date, and what should be done in the future.

This commentary is a prelude to the special section planned for the October issue of *Michigan Medicine.* In that issue, the chairman of the MSMS Committee to Assist the Impaired Physician will describe how his committee works, and a physician who has been ill, been contacted and helped through rehabilitation by the MSMS committee will tell his personal story.

Doctor Bates

Doctor Burton

Doctor DeWitt

Doctor Mandell

Doctor Sargent

Doctor Werner

Richard C. Bates, MD
Lansing:

Impaired physicians fall into three classes: hopeless, doubtful and treatable. Hopeless physicians are brain damaged by trauma, tumors or time; doubtful are physicians with character disorders and those afflicted by schizophrenia. The remainder are those with mood alterations ("affective disorders") and — the largest group of all — physicians addicted to drugs and/or alcohol. In this last set, recovery rates of 90 percent are reported.

Despite this high potential for recovery, hundreds of salvageable physicians are lost each year in the United States through suicide or loss of license to practice. Since most of those who recover do so because of intervention by colleagues, these tragedies stem, in large part, from the failure of unimpaired physicians to diagnose and get involved.

Failure to diagnose is the result of ignorance of the kinds of behavior that indicate substance abuse; failure to intervene comes from unwarranted embarrassment over a colleague's impairment, or else anger that he is "breaking the rules." Over all there is a reluctance to appoint oneself as a mentor to slight acquaintances.

The dangers of non-intervention include damaged patients, malpractice, a physician barred from practice or dead from suicide, and a continuing black mark against our profession for not caring for its members.

Each physician is not asked to be an expert in detection or therapy, but every physician must be persuaded to consult with such experts promptly whenever he has questions about a colleague's behavior.

Nowadays, those experts are increasingly plentiful because their ranks are largely composed of recovering, once-impaired physicians.

Thus does success in rehabilitating sick physicians breed success, where, in the past, failure bred disaster.

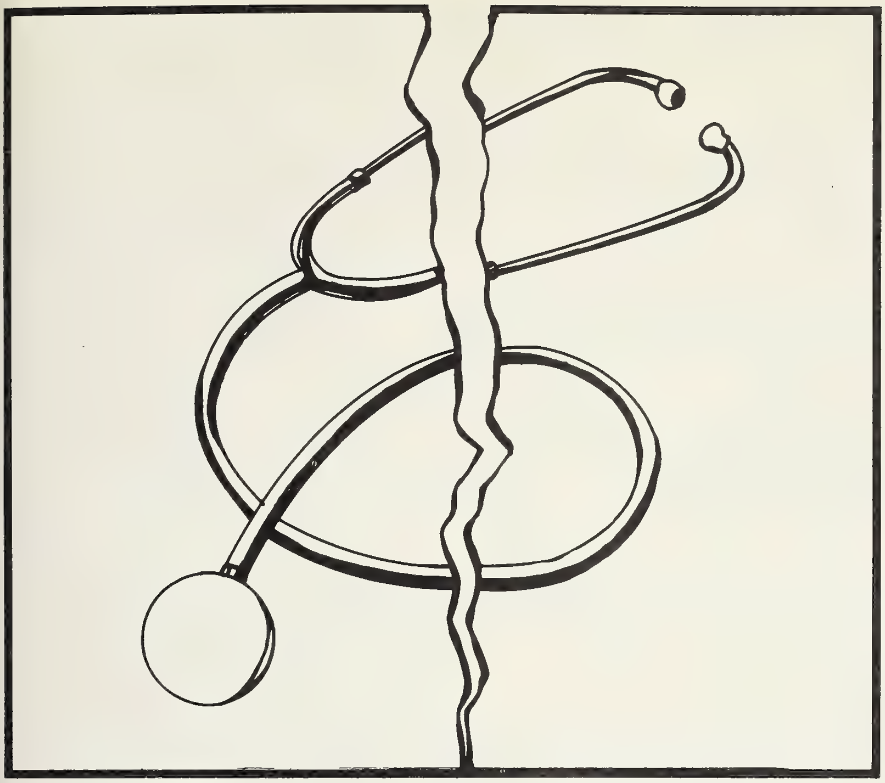
Doctor Bates is a contributing editor to* Medical Economics *and was chairman for many years of the MSMS Committee on Drug and Alcohol Abuse.

Robert D. Burton, MD
Grand Rapids:

A distressing loss of needed medical talent and waste of valuable manpower occurs when a physician becomes disabled through alcoholism, drug abuse, or psychological impairment. It is estimated that between 8-10% of our colleagues are thus handicapped. A sizable number of "impaired physicians" can be counted in Michigan.

MSMS goals, after recognizing the enormity of the problem, should be two-fold, in my opinion. I feel our approach should be a position of advocate rather than adversary for the physician. With this, however, our aim also must be protection of the public and preservation of the integrity of the profession.

In addition to the actions of our MSMS Committee to Assist the Impaired Physician, I feel we might



work to include adoption of an amendment to the Medical Practice Act fashioned after the AMA model bill known as the "Disabled Physician Act."

Also, a conference of doctors experienced in treating the above problems should be held and the recommendations given widespread distribution to the local component societies.

Additionally, local panels could be established to handle such cases, including identifying and confronting the impaired physician, setting into motion a program of therapy, and subsequently following up and supporting after therapy is completed. Funds might be obtained through direct use of a portion of the annual medical licensure fee that each one of us pays each year.

In this problem of our profession, the answer to the age-old question of "Am I my brother's keeper?" should be "definitely yes"!!

Doctor Burton is an AMA alternate delegate and member of the MSMS committees on state legislation and regulations, and member benefits.

Donald E. DeWitt, MD Kalamazoo:

Q: Do I believe MSMS concern with "impaired physicians" is appropriate?
A: Emphatic yes.

Q: How wide spread is the problem, in my view?
A: I'll confine my remarks to FP residency programs. According to one recent survey there were 304 total problems in 325 residency programs. They were from minor to major. The major categories included drug abuse, alcoholism, economic, mental and emotional. The minor categories included fatigue and immaturity.

Q: What should be done?
A: There should be active programs which a) identify the problem b) set up a preventative program c) set up a rehabilitation program. All three of these are rather widely used in FP residency programs but to varying degrees. The AAFP has sponsored and produced some short AV materials that cover some aspects of these broad categories.

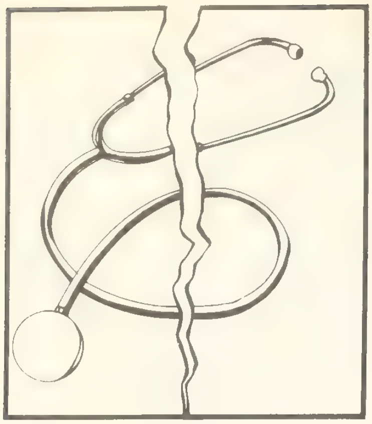
Q: What should MSMS do?
A: This is difficult to answer. It depends on resources and people available. A "grant" approach toward starting this kind of program might be one route. At least an identification program using component county medical societies might be the place to begin followed by a "task force" approach to preventative and rehabilitative programs.

Doctor DeWitt is president-elect of the Michigan Academy of Family Physicians and a member of the MSMS Committee on Public Service.

Gerald H. Mandell, MD Detroit:

In order to be successful in devising a program to assist the impaired doctor, Medical Societies have to be prepared to take positive action and to expect that there will be some positive response from the physician. Although our county medical society has a counselor service available to provide psychiatric services, the committee is seldom called for action, and in fact, it probably does not meet more than once a year.

The Ethics Committee of the Wayne County Medical Society has been able to insist that our counseling service be used by physicians who have sought membership when



they are in a recovery phase from past indiscretions. In addition, we have required quarterly reports from the psychiatrist whom the physician continues to see during any probationary period placed upon him.

Because in some instances physicians are too ill to understand that we in our medical society are attempting to help them rather than to interfere with their practice, we would best turn to our psychiatric colleagues for help.

Success of our medical societies in rehabilitation must require the cooperation of the impaired physician and his willing associates.

Therefore, I believe that each county medical society could establish a concerned group of physicians who would volunteer their services for the problems of neurosis, alcoholism and drug addiction and that the medical societies should publicize the availability of help for the impaired doctor.

If the program is successful, we might find more of our doctors willing to ask us to help their physician friends who are having a problem — allowing us to be active rather than passive.

Doctor Mandell is an alternate AMA delegate, and chairman of the MSMS Task Force on Fraud and Abuse.

D. A. Sargent, MD
Southfield:

Organized medicine has tardily but effectively begun to make up for years of neglect of the important problem of psychiatric morbidity in physicians.

Attitudes have slowly begun to change from punitive ostracism to active concern for rehabilitation of physicians who slip in their professional practice.

A fruitful coalition has been established here in Michigan between the MSMS Committee to Assist Impaired Physicians and the MPS Committee on the Well-being of Physicians. We now work together toward more effective casefinding, intervention, treatment and rehabilitation of impaired physicians.

Some aspects of the problem that have been emphasized by the combined committees are:

- Health insurance for all physicians, with parity of coverage for psychiatric disorders.
- Promoting staff health and well-being committees in hospitals and (in smaller counties county medical societies) in order to facilitate early reporting and intervention leading to treatment for impaired physicians.
- Promoting the development of training materials to assist hospitals and other groups interested in developing health and well-being committees.
- Providing technical assistance to groups wishing to form health and well-being committees and maintaining a roster of psychiatrists willing to treat impaired physicians.
- Promoting programs and providing speakers to discuss impairment in physicians and how to manage this problem.

The Board of Medicine has supported our work by displaying a humane and reasonable attitude toward formerly-impaired members believed to be rehabilitated and ready to resume practice.

Gratifying results have been achieved, often with the supervisory assistance of a colleague who monitors the practice for a time to assure adequate performance without risk to patients. The results of this program suggest that the impaired physician may be a gratifying patient to treat and the work of helping in the rehabilitation rewarding.

Of course each physician restored to functioning represents a great social and financial gain, in addition to the benefits conferred on the physician and his family.

As one of the pioneering societies in our concern for the impaired physician (the MSMS program to aid impaired colleagues was launched in 1974), we may take pleasure in seeing the idea spread and take pride in the contributions Michigan has made so far.

Doctor Sargent is president, Michigan Psychiatric Society, and past-chairman, MPS Committee on the Well-Being of Physicians. He is a member of the American Psychiatric Association's Task Force on Impaired Physicians.

(continued on page 480)

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Paul T. Werner, MD
Escanaba:

Physicians physically too ill to practice effectively, with drug or alcohol dependence, or with mental-emotional problems are termed "impaired physicians."

These physicians, practicing in virtually every medical community, pose a dilemma to the remainder of physicians and evoke a cacophony of competing emotions in medical colleagues.

The foremost subject of concern is the patient of the impaired physician. The patient has the most at risk and may be the last to know or recognize the problem in his own physician.

When the first hints that the impairment exists are noted, we family members tend to deny the problem or rationalize its existence. Next comes a silent collusion among the family members to protect the colleague from himself.

The conspiracy is one of "caring" — a misguided and mistaken attempt to protect our handicapped colleague and friend. A fragile and unstable support system is constructed, built on the foundation of denial, rationalization, and isolation.

And, like the house of cards it resembles, this system tumbles, often unexpectedly and dangerously, when the impaired doctor publicly embarrasses himself or commits a grave medical mistake. Then drastic measures are often taken, severely limiting the physicians's activities and destroying his public reputation. The impaired colleague is now exposed and, fully confronting his problem maybe for the first time, may well and justly inquire why his professional family members did not help him sooner.

The Michigan State Medical Society must take responsibility for the early identification and assistance of our impaired colleagues. The society can assist the profession and the people of Michigan in two ways to serve the impaired physician:

1) Raise the general consciousness of the public and professionals, both physicians and non-physicians, to the problem of the impaired physician. Talk it up! Get the problem out of the closet and into general discussion so that everyone knows our concern and learns that help is available. Remove the stigma from impairment and from those who seek to help by confrontation or reporting.

2) Develop and publicize a system of support within the State of Michigan. This system should have a widely known "hotline" number for anonymous contacts.

Backing this up should be a regional network of six to 10 trusted physicians to whom the concerned caller could be referred.

These regional physicians would meet periodically as a state society committee. They would acquaint themselves with available support services within the state and its many regions and would maintain liaison with the Michigan Board of Medicine. They would serve as regional resource persons to answer questions and direct concerns to the state level.

Special training workshops and consultants would facilitate assistance to concerned colleagues. These regional physicians could counsel the contact person and assist in confronting the impaired physician and direct him to appropriate care and support.

Most importantly, this committee would serve as a friend of the impaired physician to guard his perogatives and encourage his return to practice following successful treatment or his graceful retirement in the face of irreversible conditions.

Doctor Werner is director of the Michigan State University's Upper Peninsula Medical Education Program.

CPT updated again; new copies available

Over 100 revisions are included in the Third Update to the Fourth Edition of the *Physicians'* CURRENT PROCEDURAL TERMINOLOGY, the American Medical Association's comprehensive system for naming, coding, and reporting medical procedures and services.

The summer 1979 Update to CPT-4 includes the following changes:

- The most extensive revison deals with urological procedures. A new section on urodynamics has been added together with a number of additional urological procedures.
- New radiology procedures include computerized tomography of the spine, endoscopic sphincterotomy by radiological monitoring, and new transcatheter techniques.
- Several new techniques in orthopedics are introduced, e.g., microvascular anastomosis in bone grating.
- In Immunology, the listing of complement esterases is extended.
- Newly coded procedures in other fields include fiberoptic sigmoidoscopy, Falope ring occlusion of the fallopian tubes, follow-up visits in critical care, and a hemoperfusion procedure.

The third update is being sent this month to individuals who have completed and returned the prepaid card included in the CPT-4 book. This and future updates to CPT-4 are provided at no additional cost to CPT-4 purchasers.

CPT-4 is available through the Order Department OP-41, AMA, P.O. Box 821, Monroe WI, 53566. Single copies of CPT-4 are $12 each.

Hospital EMS categorization should serve as useful tool for health care

By John G. Wiegenstein, MD
Lansing

Categorization of hospital emergency departments has generated a great deal of controversy in the past year. I would like an opportunity to comment on this situation.

Categorization of hospital emergency departments is a good concept and should be supported by the medical profession. It provides information necessary for patient management and transfer decisions as well as the information necessary to plan for an emergency medical services system.

Although the concept of categorization is good, the process by which this is accomplished has been the focal point of much controversy. The most commonly heard criticisms are that the categorization criteria are unrealistic, particularly in rural areas, and that the categorization process promotes a sense of competition between hospitals that is sometimes detrimental to health planning and patient care policies.

State and federal pressures

The blame for this situation cannot be placed entirely on the Michigan Department of Public Health. The Department is pushed from two directions on the issue of categorization of emergency rooms — state legislation and federal funding.

State legislation (PA 323 of 1978) requires the department to develop criteria for a statewide categorization process. These criteria have not yet been promulgated because they must first be reviewed by the Statewide Emergency Medical Services Advisory Council which has only recently been appointed by the governor.

The federal government has been much more direct with its request for categorization. The Michigan Department of Public Health was notified by the Department of Health, Education and Welfare that continued funding for EMS development would depend on the ability of the state to complete an ambitious system of vertical, horizontal and circular categorization. The Michigan Department of Public Health was forced to develop categorization criteria for this complex process and initiate a categorization scheme in order to maintain eligibility for federal grants. One might expect that such a hurried process would result in a high level of dissatisfaction among physicians, hospitals, and health planners.

Yet despite initial widespread concern, the site review teams were generally well received by the participating hospitals. It is interesting to note that 85% of Hospital Emergency Departments participate and have expressed satisfaction with their designations. Even the dissatisfaction that was expressed is becoming a useful tool.

In response to physician concern, the Michigan State Medical Society has created an ad hoc committee on EMS Categorization Criteria. This ad hoc committee, which is chaired by Brooker Masters, MD, Baldwin, is charged to work with the Michigan Department of Public Health to improve the process of emergency room categorization. The ad hoc committee has requested the Michigan Department of Public Health to create a special advisory committee to work on this issue. The department's initial response was enthusiastic and we are waiting for written confirmation of their intent.

Other groups, including the Michigan Hospital Association and some Health Systems Agencies, have also formed committees to recommend changes in the categorization criteria. The time seems right for such changes. The funding requirements of the federal government have been met and the Michigan Department of Public Health is turning its attention to ratification of criteria for state-mandated categorization. Naturally, they do not want to repeat the shortcomings of the first round of categorization, and are anxious to work to make any necessary modifications in the categorization criteria.

Categorization useful tool

We have undergone the first round of emergency facility categorization, and it was turbulent. I am confident that with the input of MSMS and other concerned organizations, future rounds can be much smoother.

The task falls to us to encourage necessary modifications in the categorization criteria and process so that emergency facility categorization becomes what it was intended to be — an inventory of the resources in each emergency facility. I am convinced that such a resource inventory is a useful tool for physicians, ambulance personnel, hospitals and health planners. I hope you will support efforts to make this categorization process meaningful and productive.

Doctor Wiegenstein

Doctor Wiegenstein is a member of the Statewide Emergency Services Advisory Council.

Doctor Shekerjian named BCBSM medical director

Doctor Shekerjian

Armen Shekerjian, MD, former medical consultant with the Michigan Department of Public Health, has been named vice president and medical director of Blue Cross and Blue Shield of Michigan.

Doctor Shekerjian, an MSMS member, will help promote BCBSM's cost containment programs and the development of alternative health care delivery systems, said William E. Stevenson, BCBSM executive vice president for external affairs.

"Doctor Shekerjian's proven abilities and rich background in health care administration and economics, and his knowledge of various health care delivery systems, including health maintenance organizations (HMOs), will be of great value in this critical position," Stevenson said.

In addition to serving as a state medical consultant for the last five years, Doctor Shekerjian practiced general surgery in the Detroit area for more than 20 years, served as assistant medical director for Detroit Edison Co., and was a physician and consultant to HMO International in Los Angeles.

His professional memberships include the Academy of Surgery of Detroit and the American Occupational Medical Association. He has also earned membership as a Fellow in the American College of Surgeons and the American College of Emergency Physicians. He is a founding member of the Detroit Cancer Club.

Doctor Shekerjian obtained his medical degree from Wayne State University, a master's degree in medical care administration from the University of Michigan, and attended the Harvard Graduate School of Business Program for Health Systems Management.

He succeeds Louis F. Hayes, MD, whose retirement will be effective in March.

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Here is MSMS discussion of FTC complaint against medical society

By Mert Scholten
MSMS Communications Chief

Are Michigan physician leaders and MSMS staff members headed for jail?

Are Michigan doctors guilty of fixing fees?

Is MSMS restraining competition among MDs?

If the answer to these questions is "No," then why didn't MSMS issue a denial of the charges made July 31 by the Federal Trade Commission when it lodged a formal complaint against the Society?

These questions and a dozen more are being asked by MSMS members upon hearing of the FTC charges. The charges were a media event in some areas where newscasters added vocal and facial nuances to the news release issued by the FTC.

Misunderstandings

MSMS leaders believe many of the charges raised and the misleading wording of the FTC news release stem from misunderstandings of the real meanings, events and actions which have taken place since the special MSMS House of Delegates meeting in October of 1977.

"The FTC alleges MSMS physicians have attempted to 'fix fees,' which connotes a group of doctors getting together in a back room somewhere and deciding to charge X number of dollars for a given procedure," says Doctor Louis R. Zako, MSMS Council Chairman.

"Nothing could be further from the truth. The FTC has elected to call fee fixing physician complaints over discriminatory payment practices which limit the patient's freedom of choice in selecting his or her doctor."

MSMS leaders and legal counsel point out that charges issued by a branch of the government bureaucracy (in this case the FTC) are not the same as a proven criminal offense. "One is innocent until proven guilty," notes A. Stewart Kerr, Legal Counsel for MSMS.

As to why MSMS didn't issue an immediate denial through the media, it should be noted that many people didn't hear or read the initial story and those who did probably didn't understand the technical details involved.

For MSMS to call a news conference, or issue a news release, reasoned MSMS leaders, would have served to again place the issue before the public (or introduce them to it for the first time) and cause greater confusion.

"Responding on the spur of the moment is not the wisest move to make in matters such as these," said Doctor Zako, who was himself the recipient of many media calls.

"We're much better off to issue some kind of formal response after the issues have been crystallized in future hearings."

Blues erred

And according to Doctor Zako, the FTC news release erred when it said that MSMS actions were against the Blues' cost containment programs.

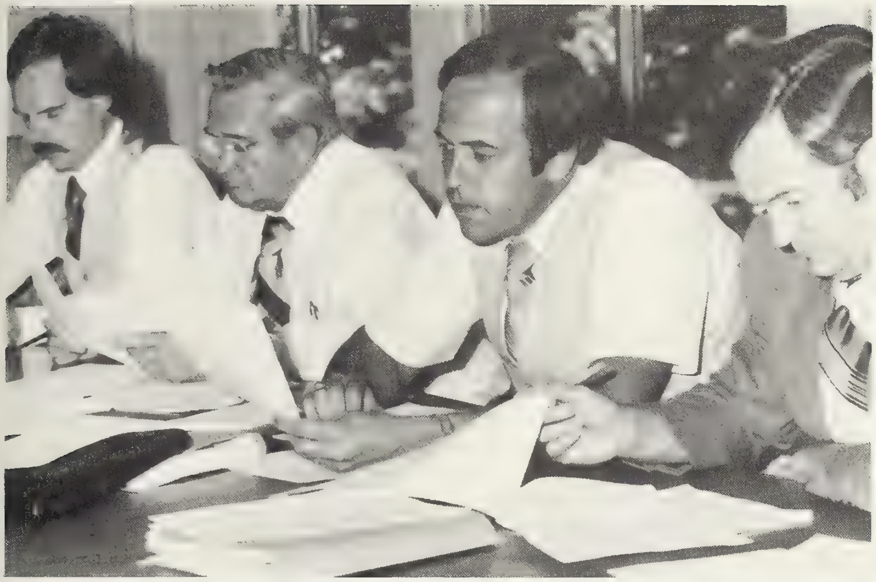
"We are *not* against cost containment. We are against the rationing of medical care on the basis of fiscal constraints without adequate physician input.

"And our House of Delegates felt that the proposed plan did not do a very good job of containing costs and of maintaining the individual subscriber's medical well-being." (The delegates rejected the plan at their 1979 meeting in Kalamazoo.)

The MSMS leadership is quick to point out the current argument is not with Blue Cross/Blue Shield, but with the FTC.

Philosophical differences

"But to understand our feelings and responses to the FTC charges, one has to understand the philosophical differences we have with the Blues over proposed cost containment measures," Doctor Zako points out.



Reviewing cost containment proposals earlier this year at MSMS headquarters are, from left to right, William Madigan, MSMS staffer, and BCBSM representatives Louis Hayes, MD, Robert Asmussen, and Thomas Bullen.

"At no time in the entire sequence of events was there any economic gain achieved or even striven for in discussions with the Blues," said Doctor Zako. "We never attempted to set any fee. We did try to offer input toward containing costs, equity for physicians' services and quality health care.

"We have a contract (implied) with every one of our patients which has nothing to do with the fact that the patient may have some third party (an insurer) who steps in to pay the medical bills.

"And under the implied terms of that contract we have an obligation to render the best possible care in the best interest of the patient's health.

"But we are now seeing third party intervention into that doctor-patient relationship in terms of decision-making. And that's where we draw the line," said Doctor Zako.

Many physicians are blaming third party payment systems for the ills which plague health care, as physicians believe insurers have over-sold patients and employers on the coverage offered in specific plans.

With inflation rampant, many physicians don't believe the best way to hold the line on health costs is to simply put caps on the amount to be expended for various services.

"Physicians need an alternative to the proposed BCBSM Target Limitation of Expenditure program. Placing caps on expenditures ultimately leads to rationing of care," said Doctor Zako. "In the Blues' case, the insurer is now seeking to make the doctor the victim by penalizing him for deciding in the patient's favor."

"We want to work with the Blues and any other insurance carrier on logical, meaningful ways of containing costs without medically shortchanging the patient. That's what our discussions have been about."

FTC charging

"Now we have the FTC telling us we can't do that and that we're guilty of all kinds of wrongdoing.

"We feel we've been vitally concerned for our patients, while defending our right to operate on free enterprise principles without some other party dictating to us the conditions under which we shall practice," said Doctor Zako.

"MSMS has no alternative as I see it but to contest the complaint. To do less would be to shirk our responsibility to our membership and to our patients, who depend upon us to guide them in proper health care decisions," Doctor Zako concluded.

MSMS officers

MSMS leaders

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John R. Ylvisaker, MD, Pontiac, *President-elect*
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Product Information as of September, 1977

U.S. Patent 2,985,558

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Contraindications and Cautions: There are no known contraindications to c use when administered in recommended doses. Should not be given immediat postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension tachycardia

Intravenous administration should not be given because of increased likelihoo of side effects

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued

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Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls

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"May I hear physicians' views . . ."

I was very interested in Doctor Ernest Griffin's remarks in the July, 1979, issue of *Michigan Medicine*. On the President's Page he says — "Others are the diabetic who either does not understand his disease or does not care, the *obese persons* who have developed a host of diseases as a result of gorging themselves and are leading their offspring in the same direction —."

He has struck a cord close to my heart and my professional beliefs. I am completely committed to the practice of Bariatrics, (from the Greek Toros — weight) as I sincerely believe — and it is scientifically proven, that obesity, as Doctor Griffin has so correctly pointed out — is the cause of many terrible killers in medicine. As we know, there are about 1,000,000 deaths a year due to obesity and its complications; heart disease, hyper-tension, and diabetes.

As the national chairman of the Public Relations Committee of the American Society of Bariatric Physicians, it is my — and our — purpose to promote an ethical concept of weight control through proper diet, exercise, and behavioral modification. Obesity kills three times the number of people as does cancer!

Our Society is interested in promoting scientific, nutritional guidelines of study in the medical schools as well, or any other disciplines in medicine.

Now, let me refer you to a statement in the same issue of *Michigan Medicine*, page 378.

There is a question from a physician to Mr. Mert Scholten of East Lansing, Chief of Communications for the Michigan State Medical Society. The question is: "I have heard there are physicians in Michigan specializing in bariatrics. What exactly is that field?" The answer from Mr. Scholten is: "Bariatrics is the study and treatment of weight control. There is an American Society of Bariatric Physicians with headquarters in Englewood, Colorado. The recognition of bariatric physicians as a subspeciality comes before the AMA House of Delegates from time to time, but the delegates so far have ruled bariatrics not sufficiently developed to be rated as such."

In light of Doctor Griffin's observations on the President's Page regarding obesity it is perhaps time for the AMA to reconsider its stand. May I hear Michigan physician's views on the matter?

Lewis D. Kaufman, MD
Flint

". . . a vital part of my 'memory time'."

It was truly a real pleasure to have a short visit with the MSMS staff at the meeting in Kalamazoo last month. The past association with all of you for so many years — pleasant years — is a vital part of my "memory time."

Thank you for the photos you sent of the "old guard." They are appreciated.

Good cheer!

"Doctor Bob"
(Robert J. Mason, MD)
Oxford, MD

"To reduce . . . credits for physicians over 65 could be dangerous . . ."

I would like to respond to Doctor Andrews' letter printed in the July, 1979 issue of *Michigan Medicine* concerning CME mandatory requirements.

I sympathize with the predicament of part-time or aging physicians having difficulties attending CME courses. However Doctor Andrews apparently has overlooked some of his options.

CME credit may be earned at hospital grand rounds, by independent reading, by writing an article or teaching local residents, all of which he could do without leaving Kalamazoo.

If he wishes to practice up-to-date medical care, he should use this opportunity to set aside some learning time, hopefully in practical areas rather than inane ones. Or he might take advantage of the annual MSMS Scientific Meeting in the fall, or the many review courses available within Michigan.

To reduce the number of CME credits required for physicians over 65 could be dangerous — akin to offering an easier-to-pass vision test for drivers over 65. If you treat patients, the public must be certain that you will take the time to remain current.

Sincerely,
Michael R. Liepman, MD
Career Teacher in Alcoholism
and Drug Abuse
Director of Behavioral Studies,
Dept. of Family Practice
University Hospital

MSMS Auxiliary active in many community service areas

Mrs. Carron

By Mildred F. Carron
Ann Arbor

It's time for a change. The MSMS auxiliary does work in cooperation with the state and county medical societies, but not closely enough.

We have a fine program of community service in many counties. This past year county auxiliaries worked with their local Red Cross chapters for blood donation days, trained young people to be good babysitters (GEMS program), helped with school immunization and scoliosis screening, visited the aged, and helped with Meals on Wheels. This was the International Year of the Child, so we promoted safe auto seating for children.

These are just some of the services.

Year of activities

In the fall we will hold two-day district meetings, with the theme, Health in the Doctor's Family. We will meet at the St. Joseph Holiday Inn Sept. 19-20 for a program with the Michigan Health Council on food and fitness. On Oct. 16-17, we will meet at St. Joseph Hospital, Flint, with the Michigan Academy of Family Practice, when we will present a program from the Chicago Center for Family Studies. At this meeting we will discuss some theories on family relations, select some of the challenges and evaluate how we might meet those challenges for our benefit. These two district meetings are for all members.

In the spring we meet in Lansing for Legislation Day. Bruce Ambrose helps us set up a good educational program. We lunch with our state legislators. We learn what is happening on both national and state levels in the legislature that effect medicine. Our Legislative Day chairman is Mrs. Donald Wild of Ann Arbor.

We work side by side with MDPAC. Mrs. Thomas Berglund of Kalamazoo is our chairman. Her husband is on the AMPAC board, the only member ever named from Michigan. We also support the American Medical Association — Education and Research Foundation (AMA-ERF). Over $44 million is currently on loan to medical students, interns and residents by banks, guaranteed by this fund. For every dollar contributed, $12.50 is available for loan. Loans are now limited to 50 for each medical school. Direct gifts also may be made, naming the medical school of choice.

In 1978-79, Michigan contributed over $39,000 to AMA/ERF. Mrs. George Hardie of Jackson is AMA/ERF chairman for Michigan.

New members welcome

The MSMS-A welcomes new members. If your county does not have an auxiliary, we will help your form one. Those who wish to join but have no county auxiliary to join may contact Members-at-Large Coordinator Mrs. Donald Heyboer of Birmingham. To form a new group, five members and bylaws put you on the books. State dues are $5 annually and national dues are $7. The national auxiliary has many excellent services.

Doctor, we hope your spouse enjoys and participates in auxiliary activities. Watch this column for future work being accomplished by the Michigan State Medical Society Auxiliary. We work hand in hand with the medical society to promote a favorable opinion of the doctor in Michigan communities. Does your spouse read *Michigan Medicine*? Let us learn together.

Mrs. Carron is president of the MSMS/A.

The MSMS Auxiliary's theme for 1979-80 is "Be a healthy bird."

These Michigan cases summarized in *Citation* AMA legal newsletter

"Supervising Physicians Liable For Improper Tubal Ligation By Resident," Michigan Court of Appeals, Jan. 17, 1979, from the *Citation*, Vol. 39, No. 7

"Patient Sues For Removal of Noncancerous Breasts," Michigan Court of Appeals, Oct. 18, 1978, from the *Citation*, Vol. 39, No. 7

"State Mental Hospital Has Governmental Immunity," Michigan Supreme Court, Dec. 27, 1978, from the *Citation*, Vol. 39, No. 7

"Appellate Court Reverses Trial Court's Decision That Hospital Was Immune," Michigan Court of Appeals, Oct. 17, 1978, from the *Citation*, Vol. 39, No. 7

"Suit Against Maker of Polio Vaccine Not Filed Too Late, Court Says," Michigan Court of Appeals, Feb. 6, 1979, from the *Citation*, Vol. 39, No. 7

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

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Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

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Medico-legal potpourri:

There are steps physicians can take to decrease their risk of liability when serving on hospital credentials committees. These steps are outlined by the past president of the American Society of Hospital Attorneys in a recent issue of the St. Paul Company's *Malpractice Digest*.

Edward E. Hollowell, JD, offers these suggestions to physicians serving on any committee responsible for evaluation of a physician's qualifications or practices:

- Investigate thoroughly.
- Insist that the committee's decision and the facts on which it is based be recorded.
- When there is disagreement with a committee decision, the objections should be placed in the record.
- Assure that individual professional liability policies cover the committee and the physicians serving.
- Encourage the hospital to carry liability insurance to cover not only the actions of individual physicians but the medical staff as a whole.

"Above all, treat these matters with the care their potential danger warrants," Hollowell concludes.

* * *

There is little Michigan physicians can do about the Michigan Licensing Bureau releasing MDs' names, addresses, specialties and degrees to anyone who wants them, according to MSMS legal counsel. There is no invasion of privacy, as the bureau must fill requests for information required for licensure, according to the Michigan Freedom of Information Act.

Legal counsel suggests physicians place stop orders with local post offices to end delivery of junk mail, work to amend the Freedom of Information Act or informally approach the Licensing Bureau in hopes it will make some effort to solve the problem.

* * *

How much can a person deduct for tax purposes from the costs of attending a benefit gala, performance or banquet? MSMS legal Counsel A. Stewart Kerr, has these comments:

IRS has issued detailed guidelines on this topic. As you know, it has become fashionable to charge a high price per ticket for certain fund raising events, but people go because they get food and champagne, or theater tickets, or whatever.

The IRS says, generally speaking, that you can deduct only the amount which exceeds the fair market value of that which you receive. If you buy a $30 ticket to a fund raising drive for an orchestra, receiving as value what amounts to a $10 seat in the auditorium, IRS claims that the deductible is only $20.

University of Detroit School of Dentistry announces a Continuing Education Seminar

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News

By Katie Brewbaker, MSMS staff

The pay is not great (only $4.00 a day) but probably more than one physician in Michigan coveted **Doctor Roy Bergman's** job. The Escanaba general surgeon just returned from Puerto Rico where he served as one of only six team physicians for the Pan American games. In addition, he'll be accompanying the USA team to the Winter Olympics at Lake Placid next year and the Moscow Olympics in the summer. Being chosen a team physician for the American athletes is quite an honor. Of over 4,000 applicants, only six are selected for the Pan Am games and eight for the Olympics.

William Bremer, MD, Detroit, is an "Old Goat," and he's proud of it, too. Actually, it's an exclusive club of seafaring men who have sailed in at least 25 Port Huron to Mackinac Island races. Doctor Bremer had this unique title bestowed upon him by the Detroit Chapter of the Society of Mackinac Island Goats.

New president of the Wayne State University School of Medicine's Alumni Association is **Burt T. Weyhing, III, MD**, of Grosse Pte. Doctor Weyhing is the 104th person to head the alumni association since its establishment in 1875.

He graduated from the University of Michigan Medical School in 1910 and has completed 65 years of practicing medicine. This record-setting accomplishment was celebrated at the 95th birthday of **A.M. Giddings, MD**, of Battle Creek. A special salute, to you, Doctor Giddings!

Stevo Julius, MD, Ann Arbor, has received an honorary doctor of medicine degree from the University of Goteborg, Sweden, in recognition of his work in nervous control of blood pressure and his contributions to the understanding of human physiology in hypertension.

Indiana Gov. Otis Bowen, MD, right, was welcomed at an MSMS reception this summer by MSMS Council Chairman Louis R. Zako, MD. Doctor Bowen spoke at a Republican dinner later that evening in Lansing.

Recipient of the American Academy of Pediatrics' Grulee Award for 1979 is **William J. Oliver, MD**, Ann Arbor. The award is given annually by the Academy to one of its members for outstanding service. Doctor Oliver was recognized for his "strong efforts over these past several years to develop a strong, innovative, and effective continuing education program for the membership."

Jeremiah G. Turcotte, MD, Ann Arbor, has been named president of the American Society of Transplant Surgeons. Doctor Turcotte, a nationally recognized authority on kidney transplants, is professor and chairman of surgery at the University of Michigan where more than 500 kidney transplants have been performed since 1964.

Frank B. Walker, MD, Detroit pathologist, carries on a long family medical tradition. Researchers of the *Medical Center News* point out that Doctor Walker is the fourth member of his family to be part of the clinical faculty at Wayne State University School of Medicine.

New presidents of Michigan Medical specialty organizations are: **Isadore Botvinick, MD**, Bloomfield Hills, Michigan Dermatological Society, and **William T. Davison, MD**, Port Huron, Michigan Orthopaedic Society.

John G. Wiegenstein, MD, Lansing, was the subject of a recent feature article in the Lansing *State Journal* which tells how he conceived the idea for the creation of the American College of Emergency Physicians 11 years ago. ACEP, which now boasts a membership of over 10,000 physicians, began with Doctor Wiegenstein's dream, one staff person, and the help of some colleagues who shared his enthusiasm, housed in a dreary, windowless office in the MSMS basement.

Michigan authors

Beverly J. Fauman, MD, Detroit, is co-author of an article on "The Amobarbital Interview" published in the July issue of the *Journal of the American College of Emergency Physicians*; the feature on "The Role of the Surgeon in the Emergency Room" appearing in the July *Bulletin of the American College of Surgeons* was written by **Alexander J. Walt, MD**, Detroit; the April 1979 issue of *Surgery, Gynecology and Obstetrics*, contains a feature by **Yvan J. Silva, MD**, Detroit, on "In Vivo Use of Human Umbilical Vessels and the Ductus Venosus Arantii"; **Jack Ryan, MD**, Detroit, authored an article entitled, "Communication with PSROs Must Be Two-Way" in the August *Michigan Hospitals*; Michigan authors of papers appearing in *JAMA* are **Jeoffrey K. Stross, MD**, and **William R. Harlan, MD**, Ann Arbor, "The Dissemination of New Medical Information," June 15; **Ellis J. Van Slyck, MD**, and **Thomas C. Adamson, III, MD**, Detroit, "Acute Hypereosinophilic Syndrome," July 13; and **Bruce Greyson, MD**, Ann Arbor, "New-Death Experiences — Relevance to the Question of Survival After Death," July 20.

Michigan Health Council gearing up Statewide Health Manpower Survey

***Special to* Michigan Medicine**

How many physician professional corporations are there in Michigan? How many partnerships?

Likely no one knows.

But more information is available now, thanks to a recent study by the Michigan Health Council.

In order to prepare for a mailing this fall to all physicians, dentists, hospitals, and clinics for the Statewide Health Manpower Survey, MHC sent a preliminary questionnaire to 9,674 MDs and DOs in Wayne, Oakland, Washtenaw and Kent counties.

"It is interesting to note that the 9,674 physicians in those four counties represent 61.4 percent of the total number of physicians in the state." points out Herbert A. Auer, executive vice president of the MHC. "Those four counties include only 44.1 percent of the state's population," he added. MHC asked the physicians belonging to PCs, partnerships and HMOs to designate one physician who will fill in the MHC survey form this fall.

Of the surveys returned to MHC, 57.1 percent of the 9,674 physicians were included. MHC was able to eliminate 3,097 physicians from the survey, thus eliminating many unnecessary forms and thus resolving problems of duplication. The fall mailing to all MDs and DOs will ask physicians in the other counties to indicate if they are organized as a professional corporation.

In the four counties the number of single professional corporations ran like this: Wayne 264, Oakland 249, Washtenaw 56, and Kent 37.

The number of multiple PCs, according to the returns, show Wayne 184, Oakland 104, Washtenaw 71, and Kent 71. These multiple PCs included the following number of physicians, in Wayne 553, Oakland 400, Washtenaw 84, and Kent 174.

The following number of physicians reported that they were in single practice and not as a PC — Wayne 317, Oakland 203, Washtenaw 85, and Kent 91.

Other physicians reported their practices in hospitals, clinics, industry and government. These more complete figures for the four counties are available by writing to Herbert A. Auer, Michigan Health Council, 1407 South Harrison Road, Suite 340, East Lansing, 48823.

The MHC will complete its health manpower survey by June 1980 to provide valuable information to the health professional associations, to the Governor and the Legislature, to state departments, and to many others.

Attention
Every Michigan Physician
Please Watch for Your

Michigan Statewide Health
Manpower Survey
To Arrive in September.

Complete and Return It
As *Soon* as Possible.

This survey is administered by
the Michigan Health Council,
a non-governmental agency,
and is funded through
The W.K. Kellogg Foundation

Health planning update

By Dennis Paradis, Director
MSMS Physician/HSA Support Center

This is the first in a regular series of health planning features planned for *Michigan Medicine* by the MSMS Physician/HSA Support Center.

Physician review urged for HSPs

MSMS is urging physicians around the state to review the Health Systems Plan (HSP) of their local Health Systems Agency and comment on its appropriateness and additional issues that should be addressed.

The Health Systems Plan sets the parameters within which the health care industry will develop. These plans cover a comprehensive range of health care concerns, many of which will directly affect the practice of medicine.

Excess hospital bed plans to be completed soon

Dec. 21 is the deadline for Michigan's HSAs to produce a plan each specifying how they will eliminate excess hospital beds in their areas.

Under the mandate of an innovative state law, Michigan is required to reduce 3,800 hospital beds over the next five years. Six of the eight Michigan HSAs are said to have excess beds (Northern Michigan and Upper Peninsula HSAs are excluded). The six are allowed 210 days to produce their plans.

In some areas of the state, the hospital bed reduction plan will cause a major upheaval in the health care delivery system. Physicians are advised to closely monitor the development of the hospital bed reduction plans.

HCC reorganizes

To comply with the requirements of state law, the Statewide Health Coordinating Council (SHCC) has reconstituted itself and elected new leadership. The 53 member SHCC is the state level policy-making board for health planning.

Terry Lee Daly is the new chairperson of the Council. Mr. Daly is a Lutheran minister from Muskegon. Margaret Morrow, an RN from Dowagiac, was elected vice-chairperson. Physicians on the Council include: D. Bonta Hiscoe, MD, East Lansing; Andrew Hunt, MD, East Lansing; Richard Potter, MD, Negaunee; Maurice Reizen, MD, Lansing; Fabius Russell, DO, Flint; Robert J. Toteff, MD, Saginaw; and Ian D. Wilson, MD, Petoskey. Doctors Hunt and Hiscoe also serve on the executive committee of the Statewide Health Coordinating Council.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma Agitated states Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused There have been reports of subjects becoming psychologically dependent on diethylpropion The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe There are reports of patients who have increased the dosage to many times that recommended Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks *Use in Children*: Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses In a few epileptics an increase in convulsive episodes has been reported *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema, *Endocrine* impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger Tenuate Dospan (diethylpropion hydrochloride) controlled-release One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215 2. Hoekenga, M.T, O'Dillon [Dillon], R.H, and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed, New York, Raven Press, 1978, pp 391-404

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A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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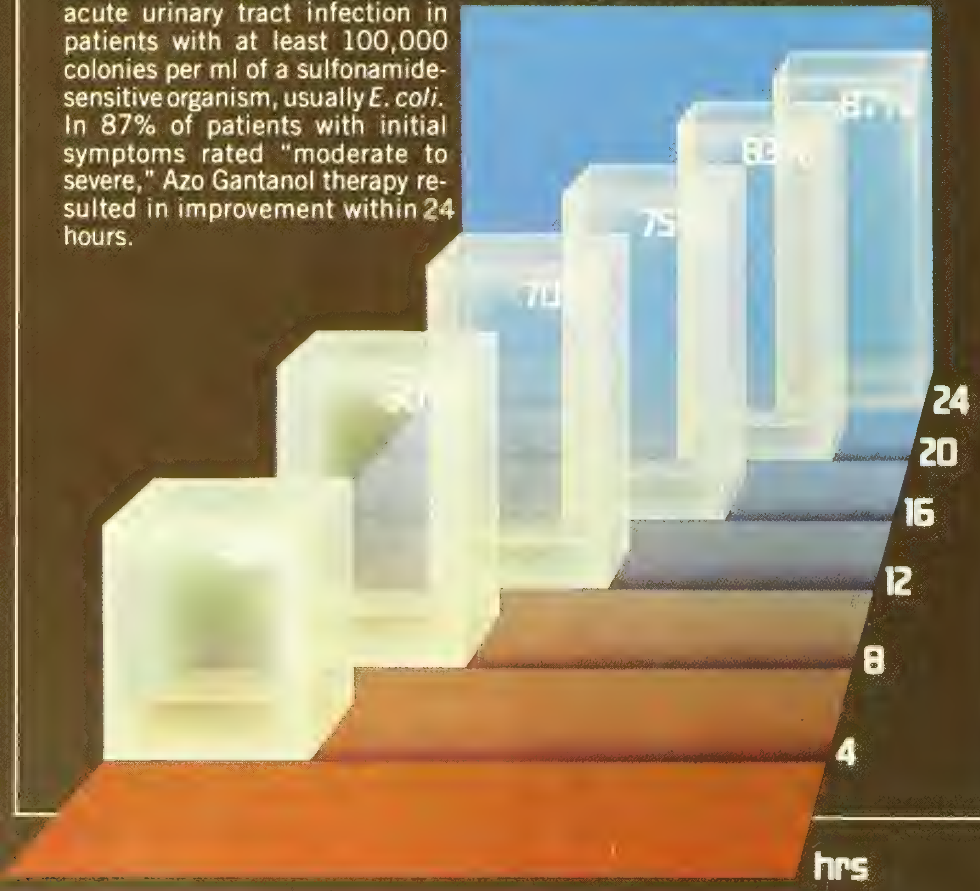

Fast pain relief plus effective antibacterial action

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Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

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Before prescribing, please consult comple
uct information, a summary of which follo
Indications: In adults, urinary tract infect
complicated by pain (primarily pyeloneph
pyelitis and cystitis) due to susceptible o
(usually *E. coli, Klebsiella-Aerobacter, Sta*
coccus aureus, Proteus mirabilis, and, les
quently, *Proteus vulgaris*) in the absence
obstructive uropathy or foreign bodies. **No**
fully coordinate *in vitro* sulfonamide sensi
tests with bacteriologic and clinical respo
aminobenzoic acid to follow-up culture m
increasing frequency of resistant organism
the usefulness of antibacterials including
fonamides. Measure sulfonamide blood le
variations may occur; 20 mg/100 ml shou
maximum total level.
Contraindications: Children below age 12;
fonamide hypersensitivity; pregnancy at te
during nursing period; because Azo Ganta
tains phenazopyridine hydrochloride it is
dicated in glomerulonephritis, severe hep
uremia, and pyelonephritis of pregnancy
disturbances.
Warnings: Safety during pregnancy not es
Deaths from hypersensitivity reactions, ag
tosis, aplastic anemia and other blood dys
have been reported and early clinical sign
throat, fever, pallor, purpura or jaundice)
dicate serious blood disorders. Frequent
urinalysis with microscopic examination a
ommended during sulfonamide therapy.
Precautions: Use cautiously in patients w
paired renal or hepatic function, severe al
bronchial asthma; in glucose-6-phosphate
dehydrogenase-deficient individuals in wh
dose-related hemolysis may occur. Mainta
adequate fluid intake to prevent crystallu
stone formation.
Adverse Reactions: *Blood dyscrasias* (agra
ulocytosis, aplastic anemia, thrombocyto
leukopenia, hemolytic anemia, purpura, h
thrombinemia and methemoglobinemia);
reactions (erythema multiforme, skin eru
Stevens-Johnson syndrome, epidermal ne
urticaria, serum sickness, pruritus, exfoli
dermatitis, anaphylactoid reactions, perio
edema, conjunctival and scleral injection,
sensitization, arthralgia and allergic myoc
G.I. reactions (nausea, emesis, abdomina
hepatitis, diarrhea, anorexia, pancreatitis
stomatitis); *CNS reactions* (headache, pe
neuritis, mental depression, convulsions,
hallucinations, tinnitus, vertigo and insom
miscellaneous reactions (drug fever, chills
nephrosis with oliguria and anuria, periart
nodosa and L. E. phenomenon). Due to c
chemical similarities with some goitrogen
uretics (acetazolamide, thiazides) and ora
glycemic agents, sulfonamides have caus
instances of goiter production, diuresis an
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exist.
Dosage: Azo Gantanol is intended for the
painful phase of urinary tract infections.
adult dosage: 2 Gm (4 tabs) initially, then
(2 tabs) B.I.D. for up to 3 days. If pain pe
causes other than infection should be sou
After relief of pain has been obtained, co
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be considered.
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dye (phenazopyridine HCl) will color the u
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What the physician should consider about finance charges for late payments

By R. Timothy Hogan, CPBC
Ann Arbor

"Should I charge interest to patients who don't pay on time? Other creditors add finance charges to their bills. What's so different about mine?"

These are reasonable, but complex questions. Physicians introducing finance charges have to ponder questions of medical ethics, local tradition, federal laws and regulations, and the mechanics of billing.

Whether the individual practitioner chooses to levy a finance charge is a decision each must make, based on personal goals and practice capabilities.

We can't decide for you, but we can tell you why some doctors are making finance charges, why others are not, and what will be required if you begin doing so. By the time you finish this article, you should have a good idea of whether you're still interested in pursuing the subject.

Why they like finance charges

1. "We've improved our collection ratio by encouraging slow payers to keep up."

Some physicians have reported improvements in their collection percentage of one or two points, not including the additional revenue from the finance charges themselves. For practices billing $1,000,000 and upward, this can mean an additional cash flow of $10,000 to $20,000 a year at the minimum.

2. "Our good-paying patients are no longer penalized along with the bad ones."

General fee increases to pay for collection efforts are avoided by making problem payers finance the cost of collecting their own delinquent balances.

3. "It was easy to program the computer for the additional material."

Most physicians who have adopted finance charges are on computer billing. However, one practice which uses a bookkeeping machine has reported that imposing finance charges increased their monthly billing time by only 24 hours for 545 accounts (including those for which no charge was assessed).

4. "We've had very few complaints from patients about our finance charges."

Patient acceptance is generally good, but when objections are received they tend to be vigorous.

5. "We had little difficulty in complying with government rules, once we knew what was required of us."

Why they reject finance charges

1. "Finance charges are unethical."

The position of the AMA's Judicial Council is that "interest charges" on overdue medical accounts are "not in the best interest of the public or profession." On the other hand, "a service charge equal to the actual administrative cost of rebilling" is "not improper."

Local tradition about ethics is another factor. Doctors in areas where medical finance charges are unknown are often reluctant to be innovative about the matter.

2. "We thought it was bad public relations."

These physicians not only are concerned about possible adverse reactions from their patients, but feel they would be inviting further criticism from government and consumers about the rising cost of medical care.

3. "Our collection ratio is good enough."

Doctors with an already high collection percentage often don't feel the additional improvement would justify the effort.

4. "There's too much extra paperwork involved."

While adapting a computer program to include finance charges is relatively easy, these doctors are on manual billing systems. They are deterred by the idea of figuring a separate finance charge for each monthly statement, and by the possibility of having to reorganize their financial records to do so.

5. "We didn't want to get mixed up with Truth in Lending."

The law popularly known as the Truth in Lending Act was passed by Congress in 1968 to help the consumer compare the various credit terms available, and to avoid the uninformed use of credit.

The physician who begins making finance charges will come under the terms of the act, and must comply with its provisions. Violations are punishable by both civil and criminal penalties, including a fine of not more than $5,000, imprisonment for not more than one year, or both.

Finally, though it is not an obligation under the law, it would be prudent to seek the advice of an attorney who is familiar with the provisions of the Truth in Lending Act as they apply to medical practices.

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

Michigan's only MD-legislator off to an excellent start

The following article is the twelfth in a series. The articles, written especially for Michigan Medicine *by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.*

By Willah Weddon
Special to Michigan Medicine

"The people here are not as bad as the press says they are. A lot of us work hard," State Senator Edward C. Pierce, MD, appraises the Michigan legislature.

"I like it here," he adds with an engaging grin.

The only medical doctor to serve as a Michigan legislator in more than 20 years, Pierce took office last January. "I'm not functioning as an MD now. But I'll keep my license," he says, acknowledging the fact that politics can be a fickle mistress.

Since his election from the 18th Senate District, however, he's dropped the MD from his name on his official stationery.

"I'm, in general, a liberal Democrat," he says of his political position, "not what they (AMPAC and MDPAC) usually support." MDPAC did assist him some during his most recent campaign, but AMPAC did not help him during two previous abortive tries for the US Congress. He finds this still rankles, having lost a 1976 congressional bid by only 365 votes. On the other hand, he has not belonged to MSMS or the AMA for 10 years, he says.

Colleagues respect him

Regardless of his political stance, however, Pierce recognizes that his colleagues in the Senate respect him for his medical background and appeared to welcome someone with his capability in their midst.

They picked him to chair the Senate Health and Social Services committee, an accolade seldom afforded a freshman Senator. He also has been asked to participate on other committees such as the Joint House-Senate committee to oversee the state mental health system; executive committee of the group overseeing implementation of the Public Health Code; Statewide Health Coordinating Council which oversees health planning in Michigan; and to serve on a special committee to reduce Medicaid costs.

During the organization battle within the Senate, Pierce played an active role and admits "some people in the UAW are angry at me for my part in the reorganization. But I believe the UAW has good legislative priorities and that we can work well together on many issues."

Malpractice, cost containment

Pierce thinks malpractice insurance should be "no-faulted." Contending the situation today is adversary, he says huge amounts of money involved in litigation could be avoided under a no-fault concept. "We're spending over 80 percent of the malpractice insurance funds for lawyers and administration, so patients end up with less than 20 cents on a dollar," he says.

"We could have patients buy insurance like they do before taking an airplane flight."

"If people had to pay out-of-pocket, it would be entirely different," Pierce says of cost containment. But he adds that doctors have lost a lot of ground by default . . . "They haven't been there."

Sen. Pierce

As he sees it, the cost containment argument involves "government regulation as proposed by the Kennedy forces" versus "marketing mechanisms where the patient decides according to cost."

"Today, patients don't have any idea of insurance costs as they are deducted from their salaries. So, even a well-meaning person might realize his hospital stay cost $10,000. But he doesn't feel it," he elaborates.

"From a physician's side, he rarely has a patient look at him and ask, 'You're going to charge me $60 for putting in three stitches?' "

In his opinion, there are various solutions to be considered: A. Forming HMOs. B. Rate setting commissions, telling hospitals how much they can charge. C. "Muddling along with the current system, where most physicians are today." D. Saying, "Let's see if we can get some marketing mechanisms."

"I'm probably in favor of the latter," he says.

As for the current of Blue Cross-Blue Shield reform legislation, Pierce thinks there's a fair chance an increased regulatory mechanism will come out of the controversy. "But I'm not sure," he hedges.

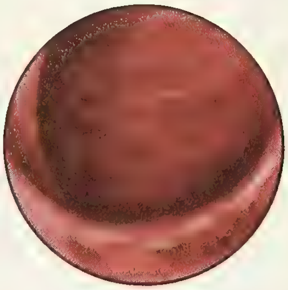
(continued on page 502)

For hemorrhoids and other anorectal conditions

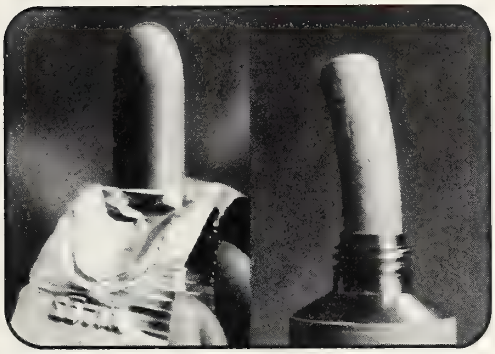
External hemorrhoids

Internal hemorrhoids

Pruritus ani


Proctitis

Anal fissures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ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

CAUTION: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg, bismuth subgallate, 2 25%, bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11 0%; also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and certified coloring in a hydrogenated vegetable oil base

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery

Anusol-HC Cream is also indicated for pruritus ani

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults. Remove foil wrapper and insert suppository into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01); with plastic applicator, detachable label

Store between 15°-30° C (59°-86° F.)

Full information is available on request

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and 15 mg HydroDIURIL® (Hydrochlorothiazide, MSD)
TABLETS
ALDORIL® D30
containing 500 mg ALDOMET® (Methyldopa, MSD)
and 30 mg HydroDIURIL® (Hydrochlorothiazide, MSD)
TABLETS
ALDORIL® D50
containing 500 mg ALDOMET® (Methyldopa, MSD)
and 50 mg HydroDIURIL® (Hydrochlorothiazide MSD)

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LEGISLATIVE PROFILE/*continued*

"Politically, the vast majority of legislators want to do something about cost-containment but they don't know what to do," he said thoughtfully. "Hopefully, I can be of help . . . if I know what to do."

Pierce's background has provided experience enabling him to serve in social services as well as medical areas of legislation. Raised in Ann Arbor, he served four years in the U.S. Air Force, returned and graduated from the University of Michigan School of Medicine in 1959. After eight years in a private general practice, he founded the Summit Street Medical Clinic to provide medical services for the lower income people in Washtenaw County.

Married and the father of four children, the eldest daughter a lawyer and the youngest in high school, Pierce was an early leader in the civil rights and peace movements. They led to his interest in politics. He served on the Ann Arbor City Council for a term in 1964-66.

Although the former practitioner readily admits he has much to learn about the workings of the Senate, he is not hampered by a lack of confidence. He refers to the legislature as a place where "meritocracy" reigns, citing Rep. William Ryan (D-Detroit) and Rep. Raymond Kehres (D-Monroe) as examples of self-made men who work hard and pay attention to details. And Pierce has gained respect, himself, for his determination to let bills sent to his committee come to the floor for open discussion.

Three major goals

"I'm going to try to do three things next year," he stated his priorities. "I plan to spend four months each looking at Medicaid and cost containment measures; looking at housing for the poor; and looking at the mental health system."

Meanwhile he's taken a stand favoring Medicaid abortion funding. "To allow the affluent to have medically safe abortions and not allow the same service for the poor is reprehensible." He also favors decriminalization of marijuana for adults. "I'd treat it the same way alcohol is treated."

Pierce is firm in another belief, too. Rather than trim a budget, reducing benefits to needy for housing, for example, he contends "the responsible action is to raise more money, which we can do."

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MSMS gains support in efforts to reduce duplication in hospital accreditation

MSMS efforts to reduce duplication in accreditation of hospitals have earned some support from the Joint Commission on Accreditation of Hospitals and the Michigan Department of Public Health.

However, MSMS has learned earlier efforts by the MDPH to have the JCAH accept state licensing procedures as the single certification of hospitals were not fruitful.

In May the MSMS House of Delegates passed a resolution:

"That the MSMS recommend that the JCAH and other accrediting bodies agree on one set of goals and standards, and that this be achieved by one unified inspection."

The resolution further called for contacting the JCAH and "other accrediting bodies," which MSMS President Ernest P. Griffin, Jr., MD, has done.

The JCAH replied to Doctor Griffin's letters with a 1,200-word correspondence describing the goals of the JCAH's recent Policy on Health Care Costs, and its efforts with over 30 state agencies to reduce duplicative surveys.

JCAH staff has been instructed to cooperate with state licensing/certification agencies and state medical and hospital associations to reduce and avoid duplication measures, but to maintain the Joint Commission's primary purpose of promoting high quality in the provision of health care services, according to John E. Affeldt, MD, JCAH president.

"In our many activities in developing joint survey activities in the various states, it has been found the most successful programs have occurred when the state medical association and the state hospital association join with the state agency responsible for certification or licensure in discussing the benefits of a joint single survey for hospitals," wrote Doctor Affeldt. "Such discussions are being held with the Michigan Department of Public Health and the Michigan Hospital Association."

In the meantime, MSMS had contacted Maurice Reizen, MD, director, Michigan Department of Public Health to tell him of MSMS concern with avoiding duplication of certification processes.

In his response, Doctor Reizen pointed out the state is mandated to license state hospitals and other health facilities and agencies. He said Hermann A. Ziel, Jr., MD, chief, Bureau of Health Care Administration, is continuing to meet with representatives of the Michigan Hospital Association to explore problems related to alleged duplication in the survey process.

However, he added that the Joint Commission has determined it is not feasible to accept the state survey and evaluation reports and supplement them only to the extent necessary to document compliance with accreditation standards not covered by state licensure.

The Michigan Department of Public Health had suggested the cooperation.

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Sept. 14-16 — AMA Regional Continuing Medical Education Meeting, Williamsburg, VA, contact: AMA Department of Meeting Services, 312/751-6503.

Sept. 19-20 — MSMS/A District Meeting, Holiday Inn, St. Joseph, contact: Mildred Carron, 2756 N. Wagner Road, Ann Arbor 48104.

Oct. 8-12 — AMA Regional Continuing Medical Education Meeting, Honolulu, Hawaii, contact: AMA Department of Meeting Services, 312/751-6503.

Oct. 16-17 — MSMS/A District Meeting, St. Joseph Hospital, Flint, contact: Mildred Carron, 2756 N. Wagner Road, Ann Arbor 48104.

Oct. 24 — MSMS Conference on State Legislation, Long's Convention Center, Lansing, contact: Bruce Ambrose, MSMS headquarters.

Oct. 27 — American Association of Medical Assistants Board Meeting, Flint Sheraton Hotel, contact: Mary Kehoe, 212 E. Broad St., Box 522, Linden, 48451.

Oct. 27-28 — American Association of Medical Assistants Leadership Training Session, Flint Sheraton Hotel, contact: Mary Kehoe, 212 E. Broad St., Box 522, Linden, 48451.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters, 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 12-15, 1980 — AMA Winter Scientific Meeting, San Antonio, TX, contact: Department of Scientific Assembly, AMA, 535 N. Dearborn St., Chicago, 60610.

Jan. 12, 1980 — 21st AMA Conference on the Medical Aspects of Sports, San Antonio, TX, contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn St., Chicago, 60610.

Feb. 2-3, 1980 — American Association of Medical Assistants Mid-Winter Seminar, Weber's Inn at Ann Arbor, contact: Frances Drawe, 2171 Medford, Apt. 33, Ann Arbor, 48104.

Mar. 9, 1980 — American Association of Medical Assistants Board Meeting, MSMS headquarters, contact: Helen Schulte, MSMS headquarters.

April 17-19, 1980 — American Association of Medical Assistants Annual Convention and House of Delegates, Hilton Inn at Plymouth, contact: Margaret Broadwell, 16686 E. 8 Mile Rd., Detroit, 48205.

OTHER MEETINGS

Sept. 14-15 — Symposium: Clinical and Radiological Evaluation of Athletic Injuries, MSU, contact: Office of Conferences and Institutes, 50 Kellogg Center for Continuing Education, East Lansing, 48824.

Sept. 15 — General meeting, Michigan Lupus Foundation, Faith Lutheran Church, Grand Blanc, contact: Michigan Lupus Foundation, 313/775-8310.

Sept. 20 — American Academy of Optometry: Michigan Chapter, MSU, contact: Office of Conference and Institutes, 50 Kellogg Center for Continuing Education, East Lansing, 48824.

Sept. 20-21 — Michigan Society for Infection Control, MSU, contact: Office of Conference and Institutes, 50 Kellogg Center for Continuing Education, East Lansing, 48824.

Sept. 25 — Transition: The Challenge, Council on Continuing Education of the American Nurses Association, University of Michigan, Ann Arbor, contact: Elizabeth A. Allen, RN, Associate Professor of Nursing, 1355 Catherine Street, Ann Arbor, 48109.

Oct. 3-4-5 — Organizational meeting, Michigan Association for Rural Health Care, Hilton Inn, Lansing, contact: William Martin, MARHC treasurer, PO Box 4001, Skidway Lake, Prescott, 48756.

Oct. 12-13 — La Leche League of Michigan, 13th Annual Fall Conference, "The Right of the Child to Good Mothering through Breastfeeding," Delta College, Saginaw, contact: Sue Stamp, AACS, 10345 West R. Ave., Mattawan, 49071 (send 35¢ to cover postage and handling for bulletin).

Oct. 13 — Michigan Speech Pathologists in Clinical Practice, 9th Annual Workshop, "Coping with a Communication Disorder: Effect on Client, Family and Speech/Language Pathologist," Mercy Center, 28600 Eleven Mile Road, Detroit, 48230 (891-5570).

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Treatment of Status Epilepticus in Children[1]

A. General supportive measures

1. Establish an airway
2. Provide oxygen
3. Start an IV, draw blood for laboratory determination, give 50% glucose
4. Reduce temperature if febrile

B. Specific drug therapy

1. Diazepam*
   Child — 0.1 to 0.3 mg/kg
   Inject directly into the vein at a rate of 1 mg/minute
   May repeat every 20 minutes x 2

If seizures stop

1. Phenobarbital 5 mg/kg IM and continue at 5 mg/kg/24 hours
   or
   phenytoin up to 6-8 mg/kg, IV

If seizures continue

1. Endotracheal tube if necessary
2. Continue diazepam
   or
3. Give phenobarbital IV up to 15 mg/kg
   or
4. Phenytoin IV 6-8 mg/kg and consider
5. Mannitol 1-2 mg/kg in 20% solution IV

---

[1] Ferriss, G (ed): *Treatment of Epilepsy Today*, Oradell, N.J., Medical Economics Company, 1978 (reprinted with permission obtained by the Epilepsy Center of Michigan, Detroit, MI 48201)

**If the seizures persist after diazepam has been given one to three times, and if the cause of the status remains unknown, respiration will likely become depressed because of the considerable quantity of diazepam, phenobarbital, or other drugs that the patient will have received.*

Presented by the Epilepsy Center of Michigan, Ernst L. Rodin, MD, Medical Center, 10 Peterboro, Detroit, 48201 (Tel: 313/832-0500).

Emergency Room Reference Card

Treatment of Status Epilepticus in Adults[1]

Drug and Trade Name	How Supplied	Total Single Dose	Administration
1) Phenytoin* (Dilantin)	2 and 5 ml ampules with 50 mg/ml (monitor pulse for cardiac arrhythmia)	13 mg/kg (ca. 100 mg total)	IV not to exceed 50 mg/min
2) Diazepam* (Valium)	2 and 10 ml ampules with 5 mg/ml	0.05 to 0.15 mg/kg (ca. 10 mg total)	IV at 5 mg/min. May repeat every 30-60 min. not to exceed 200 mg in 24 hours
Monitor and be prepared for possible cardiorespiratory arrest.			
3) Phenobarbital (Luminal)		8-15 mg/kg	IV slowly, 10 to 15 minutes
	(Do not use in combination with diazepam)		
4) Paraldehyde	bottle (stock)	0.1-0.15 mg/kg	IM, rectally (IV if urgent); may repeat every 2-4 hours
5) Lidocaine	Vials of 1% (10 mg/ml) and 2% (20 mg/ml)	5-10 mg/kg/hr	Calculate rate for IV drip

Monitor blood pressure, pulse and EKG activity periodically.

*When used together, the full recommended doses of both drugs should not be repeated.

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and in 8 ml. multiple-dose vials,
both in packages of 10.

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When painful spasm
is the presenting
symptom . . .

..in the functional bowel/irritable bowel syndrome*

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(dicyclomine hydrochloride USP)

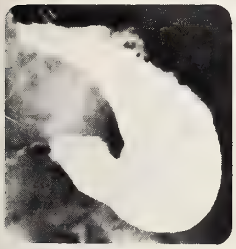
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

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Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS. Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia; urinary hesitancy and retention, blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness, drowsiness; weakness, dizziness; insomnia; nausea, vomiting, impotence, suppression of lactation; constipation; bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION. Dosage must be adjusted to individual patient's needs

Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults.* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water) Bentyl 20 mg.. *Adults* 1 tablet three or four times daily Bentyl Injection: *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used

Product Information as of October, 1978

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Seven County Committee held as a national model

In a recent publication, the AMA cited Michigan's Seven County Committee as a model for physician involvement in health planning. The Seven County Health Planning Advisory Committee is comprised of MDs and DOs from the component societies in the seven counties that comprise the South East Michigan Health Systems Agency.

The purpose of the committee, which began operating about 15 months ago, is to increase the influence of physicians on consumer-dominated HSAs. The Seven County Committee, chaired by James Fryfogle, MD, has developed a working relationship with the Southeast Michigan HSA and has been very successful in bringing the physician's perspective to the forefront in the health planning process.

The concept of the Seven County Committee has served as a model for the development of physician organizations in other Michigan Health Systems Agencies.

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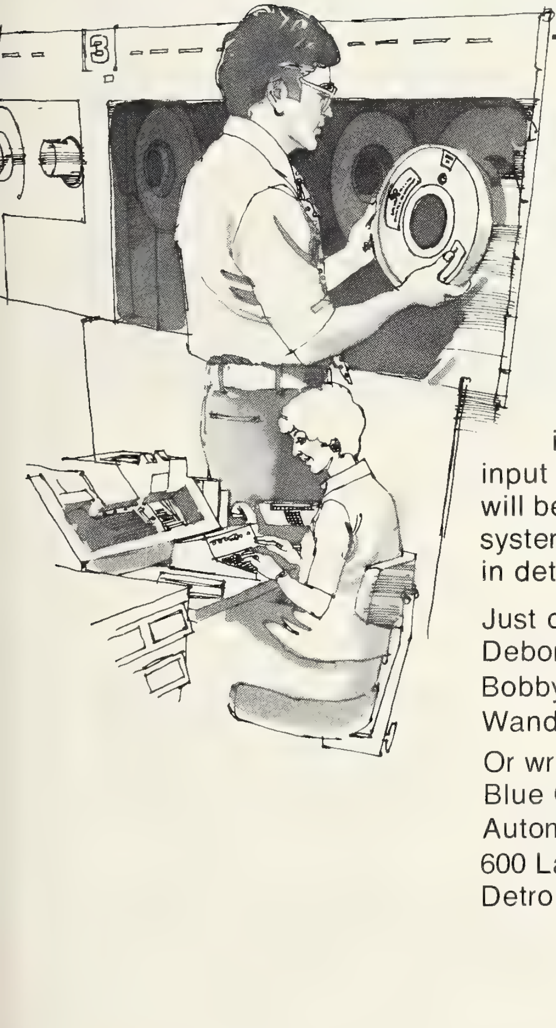

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Category I courses

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Sept. 10-Nov. 12, Pediatric Seminar IV. Location: Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 20 hours of Category I Credit.

Date: Sept. 13-14, The Michigan Association of Blood Banks Annual Scientific Meeting. Location: Plymouth Hilton, Plymouth. **Sponsor:** Michigan Association of Blood Banks. **Co-Sponsor:** Pontiac General Hospital. **Cost:** Members, 1-day, $10, two-days, $20; Non-members, 1-day, $15, two-days, $30. **Contact:** Miss Ruth Kroepel, Central Office Manager, 17150 Bentler #201, Detroit, 48219. **Approved for:** 11 hours of Category I Credit.

Date: Sept. 14-15, Clinical and Radiological Evaluation of Athletic Injuries. Location: Kellogg Center, East Lansing. **Sponsor:** Michigan State University departments of Radiology and Athletic Medicine. **Cost:** $100. **Contact:** Thomas S. Arle, MD, Department of Radiology, MSU, B220 Clinical Sciences Building, East Lansing, 48824. **Approved for:** 10 hours of Category I Credit.

Date: Sept. 17-21, 6th Annual Family Practice Review. Location: Wayne State University School of Medicine, Scott Hall, Detroit. **Sponsor:** Wayne State University School of Medicine. **For:** Family Physicians. **Contact:** Wayne State University School of Medicine, Division of CME, 1206 Scott Hall, Detroit, 313/577-1180. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 19-21, Real Time Ultrasound for the Private Obstetrician/Gynecologist. Location: Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** Department of Obstetrics and Gynecology. **Enrollment:** Limited to 25, pre-registrants only. **Cost:** $500. **Contact:** Towsley Center for Continuing Medical Education, Ann Arbor. 313/764-2287. **Approved for:** 21 hours of Category I credit.

Date: Sept. 20-22, Midwest Cancer Seminar. Location: The Concourse, Madison, Wis. **Sponsor:** Wisconsin Clinical Cancer Center, Center for Health Sciences Midwest Children's Cancer Center, American Cancer Society — Wisconsin Division, Eastern Cooperative Oncology Group, and Cancer Education Committee of Wisconsin Clinical Cancer Center. **For:** Physicians engaged in primary care and oncology-related specialties. **Cost:** $58. **Contact:** Wisconsin Clinical Cancer Center, 1900 University Ave., Madison, WI 53705, 608-263-6919. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 22, Radiology Update. Location: Benson Ford Education & Research Center. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** $70. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 23-26, International Conference, Toxic Substances in the Human Food Chain: Implications for Public Health Practice. Location: Radisson-Cadillac Hotel, Detroit. **Sponsor:** Michigan and American Public Health Associations. **Co-sponsor:** MSMS CME Programming Committee. **Cost:** $100. **Contact:** Ken Klegon, MPHA, 403 Seymour, Lansing 48914 (Tel. 517/484-3044.) **Approved for:** Up to 12 hours Category I Credit on an hourly basis.

(continued on page 516)

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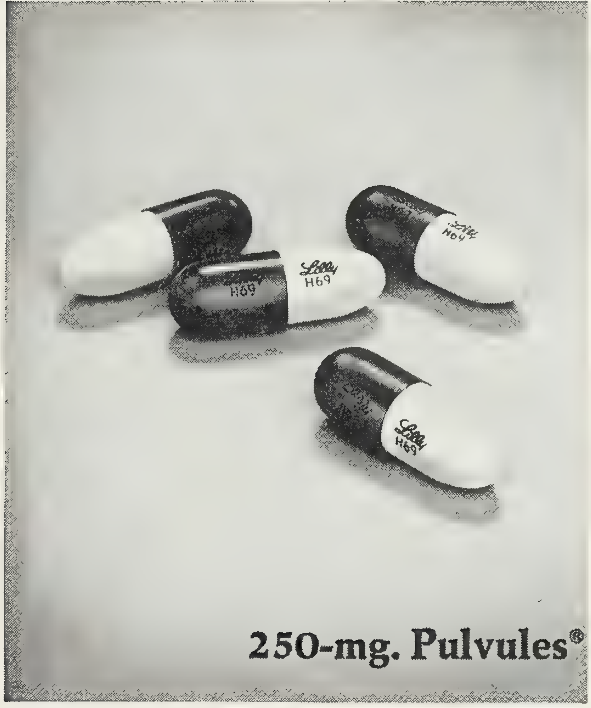

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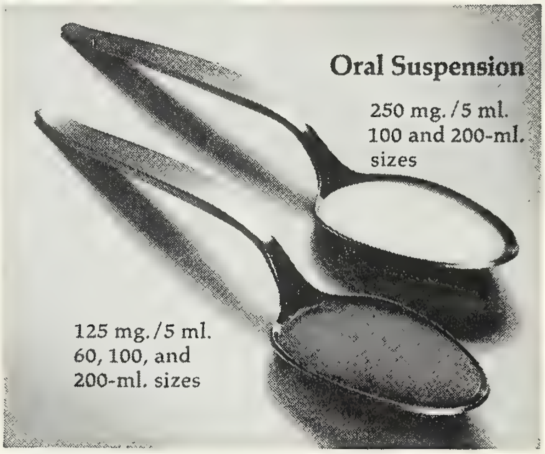

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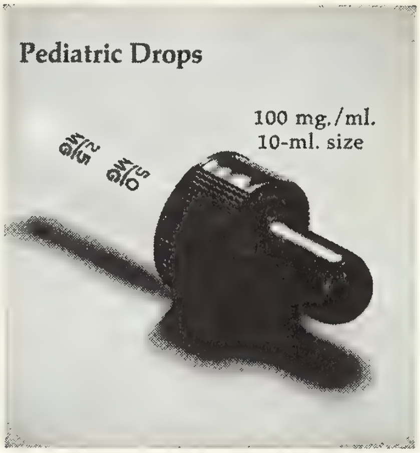

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CATEGORY I COURSES/*continued*

Date: Sept. 25-26, **Dr. Cyriax — Orthopedic Evaluation. Location:** Northland Inn, Southfield. **Sponsor:** Michigan Physical Therapy Association, Eastern District; The Department of Rehabilitation Medicine, Sinai Hospital of Detroit. **For:** Orthopedists, rheumatologists, physiatrists, family physicians, internists and physical therapists who are daily involved in the care of patients with orthopedic disorders. **Cost:** $85. **Contact:** Sharon Ferrara, RPT, % A.P.T.A., 9832 Cranston, Livonia, 48150. **Approved for:** 14 hours of Category I Credit.

Date: Sept. 26, **Arthritis Update. Location:** Sheraton Inn, Kalamazoo. **Sponsor:** Southwestern Michigan Academy of Family Physicians. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Family Practitioners and other interested medical personnel. **Cost:** $35 SWMAFT members, $40 others. **Contact:** Donald DeWitt, MD, SMAHEC Family Medicine Center, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 8 hours of Category I Credit.

Date: Sept. 26, **Diabetes Update. Location:** Saint John Hospital, Detroit. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Sept. 27-30, **American Medical Association Regional Meeting. Location:** Sawmill Creek Lodge, Huron, Ohio. **Sponsor:** Ohio State Medical Association. **Cost:** $85 per course. **Contact:** Department of Meeting Services, AMA, 535 North Dearborn Street, Chicago, IL 60610, 312/751-6000. **Approved for:** 5 credit hours per course, 1 course per day.

Date: Sept. 28-29, **Medical and Surgical Approaches to Gastrointestinal Diseases in Children. Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Education, Dept. of PGM/HPE. **For:** Pediatricians, family practitioners, surgeons, and other physicians who provide care for children. **Cost:** $110. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 10¼ hours of Category I Credit.

Date: Sept. 29, **Lower Extremity Amputation. Location:** Hurley Medical Center, Flint. **Sponsor:** Dept. of Continuing Medical Education and Physical Therapy. **For:** Physicians, physical therapists, and residents. **Cost:** $20. **Contact:** Richard D. Garlick, Director, CME, Hurley Medical Center, Flint, 48502 313/766-0142. **Approved for:** 6 hours of Category I Credit.

Date: Sept. 29-30, **Burns Clinic/Northern Michigan Hospitals 7th Annual Medical Meeting. Location:** Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center P.C. and Northern Michigan Hospitals, Inc. **For:** All physicians. **Cost:** $100. **Contact:** G. A. Uhlich, MD, Chairman Education Committee, Burns Medical Center, Petoskey 49770. 616/347-7000, Ext. 422. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 3, **7th Annual Arthur Tuuri Interdisciplinary Seminar. Location:** Hurley Medical Center, Flint. **Sponsor:** Mott Children Health Center. **Contact:** Ray Dakoske, 313/766-0142, ext. 284. **Approved for:** 5 hours of Category I Credit.

Date: Oct. 3-5, **Blood Coagulation: Clinical and Laboratory Aspects. Location:** Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Education. **For:** Physicians with a major interest in hemostasis. **Cost:** $190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 22½ hours of Category I Credit.

Date: Oct. 5-7, **Michigan Regional Meeting, American College of Physicians. Location:** Boyne Highlands, Harbor Springs. **Sponsor:** Michigan Chapter American College of Physicians. **For:** All interested physicians. **Cost:** $25. **Contact:** Boy Frame, Governor, Michigan Chapter American College of Physicians, Henry Ford Hospital, 2799 W. Grand Boulevard, Detroit, 48202. 313-876-2373. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 5-7, **Anesthesia and the Circulation. Location:** The Homestead, Glen Arbor. **Sponsor:** Michigan Society of Anesthesiologists and the U-M Anesthesiology Dept. **For:** Anesthesiologists. **Cost:** $75. **Contact:** University of Michigan, Dept. of Anesthesiology, F 3820, Mott Hospital, Ann Arbor, 48109, 313/763-2435. **Approved for:** 9 hours of Category I Credit.

Date: Oct. 10, 17, 24 & 31, **Rehabilitation Medicine for Psychiatrists. Location:** Zuckerman Auditorium, Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., Detroit, 48235. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 11, **Second Annual Doctor Jacob J. Miller Psychiatric Seminar. Location:** Mercywood Hospital, Ann Arbor. **Sponsor:** Mercywood Hospital. **For:** Psychiatrists. **Cost:** None. **Contact:** Dr. Gerard Schmit, Medical Director, Mercywood Neuropsychiatric Hospital, 313-663-8571, ext 261. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 18-19, **New Aspects of Cardiovascular Diagnosis. Location:** Benson Ford Education & Research Center. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** $130. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 18-19-20, **Implant Surgery for Joints and Tendons in the Hand. Location:** Blodgett Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand, Blodgett Memorial Medical Center. **Cost:** $250. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. 616/774-0440. **Approved for:** 19.5 Category I credits.

Date: Oct. 20-21, **Nuclear Medicine in Oncology. Location:** Hurley Medical Center, Flint. **Sponsor:** Central Chapter, Society of Nuclear Medicine and Hurley Medical Center. **Contact:** Central Chapter, Society of Nuclear Medicine, P.O. Box 160, Crystal Lake, IL 60014. **Approved for:** 11 hours of Category I Credit.

Date: Oct. 26-27, **Parenteral Nutrition. Location:** Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** U-M Office of Continuing Education. **For:** Physicians, pharmacists, nurses and dietitians who manage patients on parenteral nutrition. **Cost:** $80. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 9¾ hours of Category I Credit.

Date: Nov. 1, **MSU Family Practice Research Day. Location:** University Club, Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine. **For:** Family Physicians. **Cost:** $30. **Contact:** Douglas McKeag, MD, Department of Family Practice, MSU College of Human Medicine, B-100 Clinical Center, East Lansing 48824. 517/353-0850. **Approved for:** 8 hours of Category I Credit.

(continued on page 518)

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CATEGORY I/*continued*

Date: Nov. 2, Legal and Ethical Aspects of Treatment for the Critically or Terminally Ill Patient. Location: Detroit Plaza Hotel. **Sponsor:** American Society of Law and Medicine, Committee on Medico-Legal Problems, The State Bar of Michigan, Michigan Association of Osteopathic Physicians and Surgeons, Michigan Hospital Association, Michigan League of Nursing, Michigan Society of Hospital Attorneys, Michigan Nurses Association and Michigan State Medical Society. **Cost:** $40. **Contact:** American Society of Law and Medicine, 520 Commonwealth Ave., Boston, 02215 (617/262-4990.) **Approved for:** 6 hours of Category I Credit.

Date: Nov. 3, Acute & Chronic Orthopeadics for Primary Care Physicians. Location: Benson Ford Education & Research Center. **Sponsor:** Henry Ford Hospital. **For:** Primary care physicians. **Cost:** $70. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 5-9, Principles of Milieu Practice: Working With the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** Institute of Gerontology. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 E. Liberty Street, Ann Arbor. 313/763-4101. **Approved for:** 30 hours of Category I credit.

Date: Nov. 9-10, Twenty-Seventh Annual Symposium on Trauma. Location: Harper Hospital, Detroit. **Sponsor:** Department of Surgery, Wayne State University and the Michigan Committee on Trauma of the American College of Emergency Physicians. **For:** All interested physicians. **Cost:** $60.00. **Contact:** Charles E. Lucas, MD, Program Chairman, Wayne State University, Department of Surgery, 313/224-0736. **Approved for:** 9 hours of Category I credit.

Date: Nov. 10, Hoffmann External Fixation. Location: Hurley Medical Center, Flint. **Sponsor:** Department of Continuing Medical Education. **Co-Sponsor:** Trauma Incorporated. **Cost:** $50. **Contact:** Richard D. Garlick, Director of CME, Hurley Medical Center, Flint, 48502, 313/766-0142. **Approved for:** 6 hours of Category I credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 28, Updating Core Knowledge in General Surgery. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Dec. 8, Seminar on Diagnostic Problems in Gynecologics, Soft Tissue, and Male Genitourinary Tract Pathology. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Dr. T. A. Reyman, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, Michigan or Dr. John G. Batsakis, Department of Pathology, University of Michigan Medical Center, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 9, 16, 23 & 30, 1980, Liaison Psychiatry. Location: Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., Detroit 48235. **Approved for:** 6 hours of Category I Credit.

Date: Jan. 16, 1980, Hypertension. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236. (313/343-4000). **Approved for:** 8 hours of Category I credit.

Date: Feb. 13, 20, 27 and March 5, 12 & 19, 1980, Child Development. Location: Auditorium, Mount Carmel Mercy Hospital, Detroit. **Sponsor:** Mt. Carmel Mercy Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., 48235. **Approved for:** 9 hours of Category I Credit.

Date: March 19, 1980, Infectious Diseases in Obstetrics and Gynecology. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: May 21, 1980, Medical Therapy in Family Practice. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

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MDPH urges Michigan MDs to screen newborns for hypothyroidism

By Thomas R. Kirk, MD
Lansing

The Michigan Department of Public Health asks the cooperation of Michigan physicians in working to prevent permanent intellectual deficits due to congenital hypothyroidism.

This condition is the most commonly preventable cause of mental retardation; it is sporadic, with an incidence of one in 4,000 to 5,000 births.

Early diagnosis and early treatment are critical in preventing permanent intellectual deficits: Eighty percent of affected newborns treated before three months of age have IQs of over 90; 30 percent to 50 percent treated after three months have IQs of over 90.

This disorder lends itself to screening in the newborn period: The fetus gets no help from the mother, as the placenta is relatively impermeable to thyroid hormones; congenital hypothyroidism is diagnosed clinically in less than 10 percent of affected newborns before two months; it is readily treated with 1-thyroxine or desiccated thyroid; and radioimmunoassays are precise and sensitive methods of measuring thyroxine and thyroid stimulating hormones in less than 20 µl (0.02ml) of blood.

In early 1977 the Michigan Department of Public Health offered hypothyroid screening of newborns to a limited number of hospitals. During 1978 more hospitals joined in the program and 52,109 newborns were screened in the 12-month period ending Sept. 30, 1978.

The department's laboratory does the screening on part of the same dried blood sample mailed in for phenylketonuria screening. All results of the tests are sent to the hospital with a copy for the attending physician. Abnormal results are reported directly to the physician by phone and letter. The importance of early definitive diagnosis and treatment, if necessary, is stressed.

Twelve infants had presumptive positive screening tests for both thyroxine (under 6.0µ g/l) and thyroid stimulating hormone (over 20 µIU/ml). All were referred by their physicians to endocrinologists for definitive diagnosis and all are now being treated for hypothyroidism. The incidence was one per 4,300 screened newborns. The cost was $1.43 per screen ($74,415 total). The cost to find each hypothyroid newborn was $6,300. On April 1, 1979 the program was expanded to screen infants born in all hospitals which request this service — 102 hospitals are now participating.

For further information, including participation of hospitals, please write or call Thomas R. Kirk, MD, Michigan Department of Public Health, 3500 N. Logan, Box 30035, Lansing, Michigan 48909, Area Code (517) 373-0657.

Established 1924

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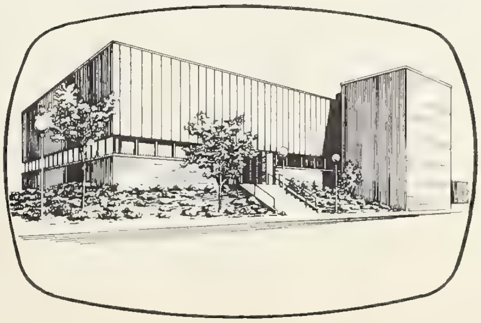

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Deaths

Alfred L. Arnold, Jr., MD
Ovid

Alfred L. Arnold, Jr., MD, Ovid, died July 26. He was 87. Doctor Arnold earned his MD from the University of Michigan Medical School in 1917. He was on the staff of Owosso Memorial Hospital until his retirement in 1961. Doctor Arnold was the first in Shiawassee County to give a blood transfusion. Doctor Arnold was a Fellow of the American College of Surgeons, a member of the Michigan Committee on Trauma and the American Medical Association. He was also a member of the American Association of Railway Surgeons and of Industrial Physicians and Surgeons.

Frank L. Bull, MD
Grand Rapids

Frank L. Bull, MD, Grand Rapids, died July 9 at the age of 82. Doctor Bull was a graduate of the Toronto School of Medicine. Until his retirement in 1961 he was associated with St. Mary's and Butterworth Hospitals. He was a life member of the American Medical Association and of the American Academy of Family Physicians.

Frederick E. Caumartin, MD
Farmington Hills

Frederick E. Caumartin, MD, Farmington Hills, died July 25 at the age of 60. Doctor Caumartin graduated from Wayne State University School of Medicine in 1944. He joined the staff of Mt. Carmel Hospital the same year and was elected chief of staff in 1968. He spent the following two years as chief of emergency room services. Doctor Caumartin earned a fellowship in the American Academy of Family Practice in 1976, and subsequently established Mt. Carmel's family clinic, where he also headed resident training.

Warren B. Cooksey, MD
Troy

Warren B. Cooksey, MD, Troy, died July 29 at the age of 83. Doctor Cooksey received his MD from Harvard University's medical school in 1926. He was chief of the department of medicine at Florence Crittenton Hospital from 1941 to 1956 and chief of staff at that hospital from 1946 to 1956. He joined Harper Hospital as a staff physician in 1928 and later became chief of Harper's department of cardiology. Doctor Cooksey had served as president of the Michigan United Fund and the Michigan Heart Association.

Robert C. Conybeare, MD
St. Joseph

Robert C. Conybeare, MD, St. Joseph, died July 12. He was 77. Doctor Conybeare earned his MD from the University of Michigan School of Medicine. He was a trustee of the Southwestern Michigan Health Care Association; a four-time chief of staff at Mercy Hospital; and a founder, vice president and medical director of Planned Parenthood Association of Southwestern Michigan.

Wilfrid L. Hufton, MD
Flint

Wilfrid L. Hufton, MD, Flint, died June 29 at the age of 71. Doctor Hufton earned his MD from the University of Michigan School of Medicine in 1940. He was affiliated with Hurley and McLaren Hospitals until he retired in 1975. Dr. Hufton was appointed the first medical director of the Flint Community Planned Parenthood Association birth control center in 1964.

Reuben L. Kahn, MD
Miami

Reuben L. Kahn, Miami, developer of the Kahn test for syphilis and University of Michigan professor-emeritus of serology, died July 22. He was 91. Doctor Kahn joined the University of Michigan faculty in 1928. He went on retirement furlough in 1956 and the Kahn Lectureship was established in his honor. But he continued to work daily in his UM laboratory until 1968, when he was named research professor of microbiology at Howard University in Washington, D.C.

Vaughn Morrissey, MD
Flint

Vaughn Morrissey, MD, Flint, died July 21 at Hurley Medical Center at the age of 73. A graduate of the University of Michigan Medical School, Doctor Morrissey served on the teaching staff of St. Joseph Hospital. He was a life member of the American College of Obstetrics and Gynecology.

William A. Murray, MD
Saline

William Aldrich Murray, MD, Saline, died July 24. He was 76. Doctor Murray received his MD from the University of Michigan Medical School in 1928. He was a retired medical editor and technical information specialist for Parke-Davis company.

Clark W. Royer, MD
Battle Creek

Clark W. Royer, MD, Battle Creek, died July 5. He was 69. Doctor Royer received his MD from George Washington University Hospital in 1934. He served as a captain in the Army Medical Corp during WWII and became associated with the first atomic bomb project at Oak Ridge, Tennessee. Until his retirement in 1970, Doctor Royer was affiliated with Battle Creek Community Hospital. He was a past president of the Calhoun County Medical Society and the Michigan Academy of Family Physicians.

Paul E. Ruble, MD
Grosse Pointe

Paul E. Ruble, MD, Grosse Pointe, who replaced the late Doctor George C. Thosteson as author of the medical advice column "To Your Good Health," died July 15 He was 52. A graduate of the Vanderbilt University School of Medicine, Doctor Ruble was a diplomate of the American Board of Internal Medicine and a member of the American College of Physicians. At the time of his death he was vice-chief of medicine at Harper Hospital, chief of Harper's internal medicine section and chairman of the hospital's emergency room committee. In addition, Doctor Ruble was an associate professor of medicine at Wayne State University.

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Positions open

GENERAL PRACTICE OPPORTUNITIES — In a small town in South Central Michigan. Good schools, hunting, fishing and many other recreational activities. Rapid rise to full partnership for the right physician. Mostly family medicine, some surgery and obstetrics. Contact W. B. Long, MD, P. C. at telephone number 517-568-4481. 9 am to 5 pm Monday thru Friday.

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POSITIONS WITH STATE OF MICHIGAN — Currently taking applications for positions expected to be available in several months. Primarily interested in board certified or board eligible internists, orthopedists, and psychiatrists. Office locations at Lansing, Oak Park and Traverse City. Salary in mid 50's with approximately 23% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, M.D., Chief Medical Consultant, (517) 373-7330. In Michigan, call toll free 1-800-292-2710.

Miscellaneous

FOR SALE — X-ray Picker 300 MA (Used). Fluoroscopic/Radiographic unit with image intensifier and electric rotating table. Packed ready to be shipped. Best offer takes all. You haul it. Call 616/962-6111.

THE WESTERN MICHIGAN PROFESSIONAL STANDARDS REVIEW ORGANIZATION, INC. has been designated by the Secretary of the Department of Health, Education and Welfare to review hospital patients under Titles V, XVIII and XIX in the following counties: Mason, Lake, Osceola, Oceana, Newaygo, Mecosta, Muskegon, Montcalm, Ottawa, Kent, Ionia, and Barry. In compliance with Federal Register dated Monday, June 4, 1979 Vol. 44, No. 108 paragraph 466.52 (b), the norms, criteria and standards currently used are available for public inspection at the WMPSRO offices. 2422 Burton, SE, Grand Rapids 49506 during normal working hours.

INVESTOR-DEVELOPER — No. 372.130 Acres of excellent farm land — prime development property. 1400 Ft. front on city street with water, sewer, gas available. 1100 Ft. on US-131. New apartment complexes on 2 sides. Adjacent to 27 hole public golf course. No. 381 Tennis-Racquetball facility. Three Tennis and four Racquetball Courts in 28,500 Sq. Ft. building on 54 acres. Excellent location and business. No. 360 Large volume Fast Food Restaurant business. Central location, city of Cadillac. No. 355 Improved Commercial property, 676 Ft. on M-115, Rural Cadillac. Excellent location for small business. North Country Real Estate By Dunbar, Cadillac, Michigan 49601, Tel. (616) 775-1323.

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SEPTEMBER 15. First International Conference on "Health Care in Pakistan," Plaza Hotel, Detroit. Approved for Category II. For information contact: Dr. Iftikhar Salahuddin, 1067 Professional Drive, Flint, MI 48504 (313) 732-4250.

TRIAL ATTORNEY AVAILABLE — 24 years experience in criminal, civil, and Administrative Board cases — available to represent persons before the MICHIGAN BOARD OF MEDICINE. Address inquiries to: C. MICHAEL KIMBER, P. C., 402 Michigan Building, Detroit, Michigan, 48226 Tel. (313) 965-1145.

LIVONIA — 7 Mile and Merriman medical building, 1350 Square Feet. Customized Suites. Immediate Occupancy. 478-2121.

Don't miss status epilepticus card

A special feature of this issue, a handy emergency room desk reference card on treatment of status epilepticus, appears on pages 507 and 508.

The card has been prepared by the Epilepsy Center of Michigan, whose medical director is Ernst Rodin, MD.

The card was provided to *Michigan Medicine* by ECM Director of Community Services Thomas J. Caughlin, who wrote that the card was prepared following the recent death of a status epilepticus patient who had not received emergency room treatment in accord with the suggestions printed on this card.

"The most serious complication of epilepsy, according to HEW's plan for Nationwide Action on Epilepsy," writes Mr. Caughlin, "is the occurrence of status epilepticus — severe, continued, uncontrolled seizures.

"If these seizures last more than 15 or 20 minutes, they are difficult to arrest. To control status epilepticus, professional help along with the administration of intravenous medication with or without artificial respiration, must be available.

"If the toll from status epilepticus — which accounts for an estimated 10 percent of deaths due to epilepsy — is to be reduced, emergency care must be available to every person who suffers from a severe form of epilepsy."

Be sure to tear out and keep this important medical information.

MEDICAL AND DENTAL OFFICE under construction — Tremendous growth location, 16 Mile just east of Ryan Road, Sterling Heights. Available soon. Call B. Monast at 313/542-7100.

PHYSICIANS OFFICE SPACE FOR LEASE located in Country Meadows Village Center, in the center of a rapidly expanding suburban population, 5 miles north of Lansing. 800 to 1300 sq. ft suites available. Separate heating and air conditioning, carpeting, vinyl wall covering, completely landscaped, ample well lighted black topped parking. Will remodel to suit. Country Meadows has many single family homes and duplexes, proposed apartments, golf courses, Athletic club and 53,000 square ft. of retail space with I.G.A. Foodliner and Muir Drugs open for business. Four (4) more stores to be open by July. For leasing information contact Anthony V. Scruby or Ronald J. Decker, Long Development, Inc. 6910 S. Cedar St., Lansing, Michigan, 517/694-8147.

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Import Motors ... 503
Eli Lilly ... 515
Mead Johnson Pharmaceutical Division ... 488
Medical Protective Co. ... 514
Mercywood Hospital ... 520
Merck, Sharp and Dohme ... 502
Merrell-National ... 486, 487, 496, 497, 510, 511, 512
Michigan Physicians Mutual Liability Company ... 483
MSMS Annual Scientific Meeting ... 519
Professional Capital Corp. ... 479
Purepac ... 517
Roche Labs ... 471, 498, IBC, BC
Sandoz Pharmaceutical ... 473
Smith, Kline, French ... 509
Stratton-Cheeseman ... 506
U. S. Air Force ... 482
University of Detroit ... 492
Warner-Chilcott ... 501
Warner-Lambert ... 512

New MSMS/PSG brochure (at right) describes services

The new MSMS/Physician Service Group, Inc., is introducing practice management and estate planning consulting services to serve MSMS members.

A brochure like the one at right is being distributed to all members to describe the services available, and in the works.It may be easily detached for handy filing in the doctor's office.

The PSG's practice management consultant is available to analyze every aspect of the physician's practice to help you improve its efficiency. In addition, the PSG estate planning consultant can help physicians implement important decisions regarding wills and trusts.

The MSMS/PSG also offers MSMS members a line of credit up to $25,000, the use of VISA and Mastercharge in the office at a reduced rate, a collection service, and in the future, will develop many more services.

Interested members may contact John Anthony, General Manager, or Robert Stanziano, Director of Financial Services, with any questions about the services offered by PSG.

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Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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Michigan Medicine
Medigram
VOL. 78, NO. 27 SEPTEMBER 21, 1979

egister now
r MSMS Public
ffairs Conference

lans are complete for the
econd Annual MSMS Public
ffairs Conference Oct. 24
t Long's Convention Center,
ansing. This year's con-
erence will be highlighted
y presentations by Cong.
ave Stockman and Walter
cClure, PhD., of InterStudy,
inneapolis, MN. It will
egin at 9 a.m.

ollowing Cong. Stockman
nd Doctor McClure in the
orning session, the after-
oon session will cover pres-
ntations from individual
hysicians who have had an
mpact on government. They
ill include W. E. Maldonado,
), on cost containment legis-
ation; David Siegel, MD, on
edicaid, and Frederick Van
uyne, MD, on the formation
an IPA-type HMO.

e conference will conclude
th the views of John R.
lvisaker, MD, MSMS president-
ect, on the medical profes-
ion in the next 18 months.

egistration is $15. The
eeting is open to all MSMS
embers, county medical
ociety personnel, and allied
ealth professionals. Please
etach the form below and
eturn it with your fee for
arly registration.

MSMS Council highlights

At its Sept. 12 meeting, the MSMS Council:

1) Re-referred to the MSMS Committee on State Legislation and Regulations efforts to deal with BCBSM reform legislation. The Council authorized the MSMS committee to act accordingly if it finds the MSMS priorities and the revised Health Care Cost Coalition's proposals in substantial agreement. The Council approved the following recommendations for the final draft of the BCBSM reform legislation:
a) That any definition of cost containment in health and medical care in the bill must include a relationship to changes in the Consumer Price Index, improvements in medical technology, adjustments to patients' quality of life, non-monetary indices, quantity of care delivered, non-medical monetary costs and medical necessity.
b) That state legislation require BCBSM to consult with a panel of physicians which would help identify problems, get and interpret information and formulate and adopt any cost containment programs.
c) That MSMS oppose rate regulations as too simple a solution to a complex problem. The resources necessary to regulation of costs, said The Council, should be more appropriately directed at accurately identifying problems within the system.
d) That a private sector commission on the cost of

egistration form. Please return to:

979 Public Affairs Conference
ichigan State Medical Society
. O. Box 950
ast Lansing, Michigan 48823

ame ____________________
ity ____________________

ame ____________________
ity ____________________

Please check one
☐ Physician ☐ Other ____________
Registration Fee: $15 includes luncheon
Amount enclosed $ ________

Please make check payable to Michigan State Medical Society.

THE NEW PUBLIC HEALTH CODE requires physicians to report abortions to the Michigan Department of Public Health beginning Oct. 1. Among the medical facts required are type of facility, procedure used, gestation and any complications. Demographic information also is asked for. Additional information, report forms and a physician's handbook are available from the Office of Vital and Health Statistics, Michigan Department of Public Health, 3500 N. Logan, Box 30035, Lansing, 48909.

CLOSE TO 200 MICHIGAN PHYSICIANS already have registered for the 1979 MSMS Annual Scientific Meeting Nov. 13-14-15 at the Hyatt Regency Dearborn. Physicians are urged to make their reservations in advance, to save time during the meeting, and to ensure first choice of courses. The 57 Category I courses scheduled have limited enrollments and are expected to fill soon. Reservation forms are printed in the Sept. 7 Medigram, the September Michigan Medicine (page 470) and are available from Sherry Fent at MSMS headquarters. (Note-Residents and interns must pay full price for the Advanced Cardiac Life Support course though other courses are free to them.)

PHYSICIANS THROUGHOUT MICHIGAN were saddened by news of the death of Ralph E. Lewis, executive director of the Michigan Medical Schools Council of Deans. Mr. Lewis passed away Wednesday, Aug. 22 in Ann Arbor. Members of the family have asked that contributions be made to the Michigan Heart Association.

physician services be created including MSMS, MAOPS, BCBSM and the public, charged with advising on the level of services by BCBSM for the next year. This commission could make specific recommendations.
e) That separate indices for hospitals and physicians be developed to measure costs and that each index identify that group of providers or the public which is responsible for fluctuations in cost.

2) Asked John R. Ylvisaker, MD, MSMS president-elect, to develop guidelines for any physicians serving on BCBSM cost containment committees, spelling out their legal and ethical responsibilities.

3) Voted unanimously to drop any further discussion of a proposed breach of contract lawsuit against Blue Cross Blue Shield of Michigan as inappropriate action for MSMS.

4) Approved guidelines for nominations to fill the coming vacancies on the Board of Medicine.

5) Directed the Council chairman to appoint a subcommittee to evaluate and advise the Board of Medicine about proposed physician assistant rules.

6) Agreed that an updated list should be compiled of physicians to assist the Board of Medicine in reviewing allegations against physicians and to serve as expert witnesses if subsequent hearings are necessary.

7) Endorsed HEW guidelines on general hospital bed supply and occupancy rates with the suggestion that federal hospitals also fall under these guidelines. The Council also warned against "rationing of health care," through a lowering of occupancy rates to such a degree that demand for hospital services cannot be met.

8) Recommended the HEW guidelines for open heart surgery, cardiac catheterization, and end-stage renal disease be referred to the appropriate specialty societies, and deferred endorsement of CT scanner guidelines until appropriate studies are completed.

EMS categorization criteria honed

Members of the new Michigan Department of Public Health Ad Hoc Committee on EMS Categorization Criteria worked to refine those criteria at their initial meeting Sept. 19 in Lansing. MSMS is represented on the committee by Brooker L. Masters, MD, Baldwin, and Richard Proos, MD, Kalamazoo. The ad hoc committee considered individual Michigan physicians' views, gathered during the summer by MSMS to aid the ad hoc committee.

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to John Anthony at MSMS/Physicians Service Group
120 W. Saginaw St., East Lansing, MI 48823.

CAPSULES/cont'd

CHIROPRACTIC SERVICES are eliminated as a Medicaid benefit, effective Oct. 1. The final appropriations bill for Medicaid says, "Chiropractic services shall be reimbursed under the Medicaid program when funds are made available." As no funds have been appropriated, "Medicaid reimbursement cannot be provided for chiropractic services rendered on or after Oct. 1," says the Medical Assistance Program Bulletin.

THE ELI LILLY COMPANY is mailing important new prescribing information about its product, Darvon, to all Michigan physicians. Physicians are urged to study this information, which warns about improper use of the drug, particularly in combination with alcohol, and avoid issuing PRN refills to patients.

MSMS/FTC proceedings underway

MSMS legal counsel were to meet Sept. 24 in Washin DC with Federal Trade Commission lawyers to schedu trial proceedings in the matter of the FTC complai against MSMS. This is the most current step in th affair which began with the FTC's subpoena in November 1978 of MSMS materials regarding Blue Cro Blue Shield of Michigan cost containment programs, and led to the filing on July 27 of the formal FTC complaint against MSMS. An administrative law judge in Washington denied the recent MSMS request for clearer language in two portions of the FTC complaint. On Sept. 17 MSMS thus filed its obligatory response to the charges levied against it by the FTC.

In other legal developments:

Oct. 2 is the date set by the Michigan Supreme Cou to hear arguments in the Seymour Friedman, MD, countersuit appeal. MSMS filed an amicus curiae brief in support of Doctor Friedman after the Mich Appeals Court allowed only limited grounds for cou tersuit.

A tentative October trial date has been set for th suit against BCBSM involving recent cutbacks in ou patient psychiatric benefits. Five BCBSM employee recently were deposed in the case.

Please see page 3 for MSMS/Physician Service Group tear-off information form

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine Medigram

VOL. 78, NO. 28 OCTOBER 15, 1979

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CONG. STOCKMAN OCT. 24 TO ADDRESS COMPONENT LEADERS

The Second Annual Public Affairs Conference to be held at Long's Convention Center, Lansing, on Oct. 24 is only one week away. Featured speakers are Cong. Dave Stockman and Walter McClure, PhD, of the Minneapolis-based think tank, InterStudy. Their informative and provocative presentation will discuss the impact of government regulation on medicine, and how doctors can effect change. A limited number of registrations is available. The $15 fee will cover registration for this all-day program and luncheon. Please send registration check, payable to MSMS to: Public Affairs Conference, MSMS 120 W. Saginaw, East Lansing, 48823.

SULES

MICHIGAN DOCTORS STUDY/SKI
B has three Colorado study/
seminars planned for winter,
0. Space is limited and
ervations are on a first-
e, first-serve basis. Dates
places of the study/ski
kages are Feb. 8-15, Snow-
s; Feb. 29-March 7, Vail,
March 21-28, Snowmass.
se attending the educa-
nal portions of the pro-
m will be eligible for
egory II CME credits.
ial events also are plan-
. Further details are
ilable from Richard
pau at MSMS headquarters.

**Register today!
Form inside
for Scientific Meeting**

Coming soon! 1979 MSMS Scientific Meeting Nov. 13-15

Time is short for interested Michigan physicians to register for the 1979 MSMS Annual Scientific Meeting. The Nov. 13-14-15 Category I CME event is scheduled for the Hyatt Regency Dearborn. Over 500 Michigan MDs already have registered, and the Basic and Advanced Cardiac Life Support Courses are filled.

Doctors should fill out the form in this issue today if they wish to enroll in other courses of their choice. 56 half-day courses are being offered for a possible total of 18 Category I credits. The list of courses appears on the registration form, with full details printed in the Sept. 7 issue of Medigram. As physicians register, MSMS is sending course confirmations and maps of the Hyatt Regency layout to each.

Interest is particularly keen among family physicians in the 1979 event, as all but one of the 57 courses are approved for AAFP prescribed credit.

Program chairman is Samuel M. McMahon, MD, Lansing. He has worked with virtually every major specialty society in Michigan and the three medical schools to plan a variety of courses full of practical advice.

All the Annual Scientific Meeting activities this year will be headquartered in a new wing of the Hyatt Regency's main floor, adjacent to the new swimming pool area.

FTC seeks MSMS documents

MSMS President Ernest P. Griffin, Jr., MD, and the presidents of eight Michigan component medical societies have been served subpoenas in the FTC case against the Society. This is the latest activity in the FTC complaint action against MSMS for alleged price fixing, restraint of trade and collusion against Blue Cross Blue Shield of Michigan. MSMS legal counsel is reviewing the subpoenas, which ask for documents purportedly related to the case.

CATEGORY I CREDITS in medical ethics are available to physicians in a unique one-day conference scheduled Nov. 2 at the Detroit Plaza Hotel. The subject is the troubling legal and ethical questions of treating critically or terminally ill patients. MSMS is a co-sponsor, along with seven other medical and legal organizations. Further information is available from the American Society of Law and Medicine, 520 Commonwealth Ave., Boston, MA 02215.

FIVE MICHIGAN MDs spout off about government regulation of medical practice in the Sept. 28 issue of the "American Medical News." The AMA weekly chose an all-Michigan panel because the state "has such a wide variety of conditions and features. Among its people, many racial and national stocks are represented, and it is distinguished alike for agriculture and industry." The physicians' comments appear in the "Impact" feature section of the issue. They are Lionel Dorfman, MD; Vance Lancaster, MD; John J. H. Schwartz, MD, and S. A. Yannitelli, MD, all of Battle Creek, and Thomas C. Payne, MD, Lansing. In addition, an RN and the president of a major professional management firm are featured.

ALL MEDICAID PROVIDERS are being required this year to conduct a self-evaluation of their facilities and programs, including employment practices, to insure the full range of medical care is available for handicapped persons. The Michigan Medical Services Administration soon will issue a bulletin explaining in detail the requirements of Section 504 of the Rehabilitation Act.

House subcommittee continues BCBSM reform struggle

Legislation to reform Blue Cross and Blue Shield a
implement health care cost containment programs is
headed for the full House Insurance Committee. A
subcommittee, which has been struggling with the
legislation since May (See August Michigan Medici
has concluded arguments on substantive issues and
ordered the document prepared for final review. T
subcommittee proposal will reflect much of the MSM
input into the four-month debate by foregoing rigi
rate setting but requiring BCBSM to develop cost
containment programs in consultation with major
provider groups. The programs would be subject
to a time trial, after which the Insurance Commissioner would determine whether they actually were
addressing three major goals: cost containment,
access to provider services, and quality care. In
essence, the subcommittee basically adopted the so
called "Shelton Recommendations" on cost containme
with some modifications. The second part of the
bill, reforming and restructuring BCBSM, provides
for a consumer dominant board of directors. After
the subcommittee reports to the Insurance Committe
the full committee plus the full House of Represen
atives must act before the bill goes to the Senate
its treatment of cost containment, rate regulation
BCBSM reform.

Medicaid screen update awaits executive action

Updating of Medicaid screens to meet contemporary
Medicare standards is pending legislative and executive action on two other appropriations bills--
the Capital Outlay bill and the Grants and Transfe
bill--which remain in the Legislature. Disagreeme
between the executive office and the legislature o
language directing screens updating has delayed im
plementation of the five per cent raise in screens
In the meantime, the executive office (Department
Management and Budget) is working to determine the
adequacy of dollars during this fiscal year. MSMS
Medicaid Liaison Committee believes the language
clearly calls for an update by Oct. 1, and is
working with state officials to obtain what it
believes is legislative intent to match Medicaid w
Medicare screens as Medicare is adjusted annually.

PLEASE SEND ENTIRE PAGE WITH CHECK

1979 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration Form for Category I CME Courses

* Courses Approved for Prescribed Credit by the American Academy of Family Physicians

TUESDAY MORNING, NOV. 13

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Overview of Pulmonary Diseases in Children, Adults and Elderly Patients
*_____ Cancer Prevention: Practical Medicine for the Family Physician
*_____ Diabetes — The State of the Art (Part I)
*_____ Hematology for Non-Hematologists
*_____ Industrial and Environmental Pollutants
*_____ New Concepts in Evaluation and Treatment of Stroke Syndrome
*_____ Preventing Physician Suicide Through Early Recognition and Proper Care
*_____ What's New in Office Gynecology

TUESDAY AFTERNOON, NOV. 13

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Birth and Death of the Endocrine System
*FULL Basic Life Support
*_____ Common Errors in ECG Interpretations
*_____ Diabetes — The State of the Art (Part II)
*_____ Gastrointestinal and Pulmonary Endoscopy: A Review
*_____ Management of Chronic Low Back Pain
*_____ Neurological Problems for the Primary Physician
*_____ Practical Approach to Electrolyte Problems
*_____ Sports Medicine for Primary Care Physicians
*_____ The Use of CAT-Scan in Making a Diagnosis Economically
*_____ Use of Psychoanalytic Knowledge in Medical Practice

The half-day courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice should the first choice already be filled.* Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, luncheon tickets, etc., must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/20/79 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

WEDNESDAY MORNING, NOV. 14

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*FULL Advanced Cardiac Life Support (A 16-hour course to run all-day Nov. 14 and 15. See tuition below.)
*_____ Alpha-Omega Session: Urinary Tract Infection in Children and Adults
*_____ Diagnosis and Treatment of Chronic Ear Disease for Primary Care Physicians
*_____ Management of Gastrointestinal Bleeding
*_____ Management of Premalignant Breast Disease
*_____ Mechanical Ventilation in Acute Respiratory Failure — Newer Techniques
*_____ Office Dermatology for the Non-Dermatologist
*_____ Pediatric and Adolescent Gynecology
*_____ Physician Role in Cost-Effective Medical Care
*_____ Stresses Within the Physician's Family
*_____ What's New in Allergy and Asthma in Children
*_____ What's New in Antibiotics and Common Office Infections

WEDNESDAY AFTERNOON, NOV. 14

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Alpha-Omega Session: Hematuria
*_____ Bronchial Asthma in Adults: Diagnosis and Management
*_____ Cutaneous Manifestations of Systemic Disease — Lupus Erythematosus
*_____ Doctor, Why Did You Cancel My Case?
*_____ Inflammatory Bowel Disease
*_____ Nuclear Medicine — Its Practical Value
_____ Otolaryngological Diseases: Latest Advances in Technique and Management
*_____ Psychology of Abortion
*_____ Reconstruction Following Mastectomy
*_____ What's New in Common Pediatric Problems
*_____ What's New in Evaluation of the Dizzy Patient

THURSDAY MORNING, NOV. 15

(8:30 to Noon, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Diagnosis and Management of Monoarticular Arthritis
*_____ Ethical Issues in Medicine
*_____ New Concepts in Congestive Heart Failure
*_____ Ophthalmology's Role in Medicine
*_____ Preventive Cardiology — The Primary Care Mission
*_____ Understanding and Treating Alcoholism and Drug Dependence
*_____ Update in Scientific Writing

THURSDAY AFTERNOON, NOV. 15

(1:30 to 5:00, including break)

(Write 1 in blank for first choice, and 2 for second choice)

*_____ Changing Concepts in Evaluation and Therapy of Coronary Artery Disease
*_____ Current Concepts in the Medical and Surgical Management of Ischemic Heart Disease
*_____ Drug Therapy in Rheumatic Diseases
*_____ Management of Common Chest Problems
*_____ Office Diagnosis and Management of Eye Movement Disorders
*_____ Ultrasonic Imaging in Clinical Radiology
*_____ Ventricular Premature Beats: Their Significance and Current Therapy
*_____ What's New in Treatment of Hypertension

Name (please print) ______________________________
(first) (initial) (last)

Street ______________________________

City, State ______________________ Zip __________

Please fill in: MSMS Member: Yes ____ No ____ Resident ____ Specialty__________

Tuition schedule for courses:
MSMS members: $4 per credit hour, or $12 for each half-day course
Non-members: $8 per credit hour, or $24 for each half-day course
Residents: No charge

Luncheon reservations: The hotel will provide luncheon each noon at $8 per person. Advance reservations are requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

Tuesday lunch ______ Wednesday lunch ______ Thursday lunch ______

- Indicate total number of half-day courses ____ × $12 (or $24) = $ ______
- Number of luncheons requested ____ × $8 = $ ______
- Registration for special 16-hr ACLS Course ($150 incl. lunch) $ ______
- Total amount due MSMS $ ______

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

CAPSULES/continued

AMA PRESIDENT Hoyt D. Gardner, MD, Louisville, KY, will be principal speaker at the annual meeting Nov. 7 of the Oakland County Medical Society. Location of the meeting will be the Northfield Hilton Inn, 5500 Crooks Road, Troy. The meeting is open to all interested physicians, spouses and guests. Reservations must be made with the OCMS office, 313/646-5400, for dinner, which begins with a 6 p.m. cocktail hour and costs $16.

A NEW Health Planning Manual for Physicians is available to interested Michigan MDs. Developed by Kevin A. Kelly of the MSMS Physician/HSA Support Center, the 60-page notebook is to be used as a resource manual for physicians already involved in health planning, and as an educational manual for those who would like to become involved.

For copies of the manual, please contact Kevin A. Kelly or Dennis Paradis at MSMS headquarters.

Despite PBB, Michiganians healthy

Michigan citizens generally are very healthy, despi low amounts of PBB in their tissues. That is the conclusion of the Environmental Sciences Laboratory of the Mt. Sinai School of Medicine, after a year a a half study of PBB concentrations. The lab's fina report, jointly written by Irving J. Selikoff, MD, and Henry A. Anderson, MD, was released Oct. 9 by t Michigan Department of Public Health.

"Information obtained from the 1,738 examinations.. demonstrates that contamination of Michigan's food supply with PBB was widespread as the result of the accident in 1973-74, and that a considerable propor of the population continues to bear some of the chemical in their tissues, five years later," says the report.

"For the very large majority," it continues, "the amounts present are rather low...(and) in general, those examined were found to be very healthy."

Highest concentrations were found in the western portion of the state, according to the report, and contaminated milk was indicated as the major source of PBB exposure. No unusual prevalence of symptoms was seen.

"By and large, the results of the survey are as goo as we could have hoped for," concludes the survey. Further details will be published in Michigan Medic

Michigan State Medical Society
120 West Saginaw Street
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Editor: Judith Marr

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Michigan Medicine

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JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

CAPSULES/cont'

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Contents

October 1979, Volume 78, Number 29

Michigan Medicine

Alcohol and drug abuse debilities, mental and physical impairments — all are suffered by physicians and may cause their practices to be severely impaired. MSMS works to seek out and help physicians with problems — please see this month's special section beginning on page 527. (Photo by Mert Scholten, MSMS staff.)

Special Section

527 **MSMS is intensifying its efforts to find and aid physicians with physical and mental problems which impede their abilities to practice; one rehabilitated physician describes his experiences;** Russell H. Smith, MD; Richard D. Bates, MD, and anonymous author.

Features

532 **Program, registration form, Public Affairs Workshop**
533 **Final details on MSMS Annual Scientific Meeting**
560 **MSMS Practical Guide #5: Cost Savings in Surgery**
567 **New Mental Health Department Director Frank M. Ochberg, MD;** Willah Weddon
576 **Meet MSU's Margaret Z. Jones, MD;** Charles Downs
578 **Manning the phones on "Call for Action — Ask the Doctor";** W. Peter McCabe, MD
587 **New list of component medical society officers**

Departments

537 **Committees; Maternal Health Conference**
538 **Meetings**
540 **Category I meetings**
542 **Health Planning Update**
548 **Business: Let MSMS/PSG help you solve office management problems;** David Laytner, PhD; **also: Physician/patient ratios are changing;** Timothy Hogan, CPBC
557 **Medico-legal**
558 **MSMS Q/A**
562 **Views: Psychiatric techniques;** Lawrence P. Tourkow, MD
570 **Welcome; New members**
582 **News;** Katie Brewbaker
592 **Letters**
594 **Deaths**
598 **Classified advertising**
600 **President's Page;** Ernest P. Griffin, Jr., MD

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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Committee on Impaired Physicians breaks conspiracy of denial

Doctor Smith

Russell F. Smith, MD
Brighton

Michigan has many resources to help physicians in trouble.

But gaps do exist. The largest hiatus is in services for those afflicted with socially stigmatized health problems. We tend to ignore problems like alcoholism, drug abuse, and psychosis in a vain hope they may go away.

Many professional groups, led by the clergy, have recognized that traditional, moralistic, pseudolegal "ethics" approaches have failed to reduce the number of such problems or promote their solution. Punishing persons with these problems simply drives them underground, only to surface beyond any possibility of help.

In a day when reliable treatment exists for all of these problems it is tragic to continue the waste of talent, lives and emotional pain attendant with the "ethics" enforcement approach. It is difficult to justify the current situation on practical or humanitarian grounds.

The MSMS Committee to Assist Impaired Physicians formed in 1976 to help our medical society provide satisfactory alternatives to traditional ethical sanctions. It works to channel the best techniques from other states and professional groups to our members. The MSMS committee joined a national movement launched by the AMA at its first conference on the impaired physician in 1975. This conference, and subsequent annual meetings, serve as a training resource and as a forum for the state committees.

MSMS policy

The MSMS committee spent its first two years developing a policy to govern our society's activities to help the physician impaired by a socially stigmatized problem. This policy statement, adopted by the MSMS Council and published in *Michigan Medicine* in 1977, commits us to:

- Vigorous efforts to reach physicians with these problems and motivate them to treatment.
- Treat physicians with these problems in a fair and humane fashion.
- Update state licensing laws to facilitate early case finding and motivate physicians to treatment.
- Develop local mechanisms to facilitate delivery of services to this group.
- Develop treatment resources if none exist.
- Serve an advocate role until all attempts to provide timely assistance fail.
- Educate all persons directly involved with this problem concerning current concepts, the treatability, and the types of help available to physicians with socially stigmatized health problems.

Physicians' problems

Why an MSMS Committee on Impaired Physicians?

Recent demographic studies reveal physicians to be surprisingly human. James West of Chicago estimates 22,700 of the 324,000 US physicians are now, will become, or have been alcoholic. G. E. Vaillant in a longitudinal study determined 36 percent of physicians were heavy alcohol and drug users compared to 22 percent of nonphysicians. Reports from the United States and several European countries indicate 15 percent of all known drug addicts are physicians. The extent of mental illness in physicians is difficult to assess because more socially-acceptable diagnoses often are substituted. We lose the equivalent of one medical school graduating class each year through suicide. The question is not if we have alcoholic, drug addicted, or emotionally disturbed physicians, but how many?

There are many reasons why we who practice a profession based on compassion fail to show the same compassion to peers with socially stigmatized conditions.

We depend on public credibility, so are very sensitive to public opinion and scandal. We try to project a superhuman image and regard human frailties as a reflection of personal failure. We assume too much responsibility for not preventing such problems. With socially stigmatized conditions, physicians experience exaggerated guilt, loss of self esteem, failure, and frustration.

Physicians even more than other professionals experience the need to deny and hide such problems. Altruism is often the smokescreen: "So many people need my help, I'll look after myself tomorrow."

Denial is made easier by the ready ability of physicians to acquire accomplices in a conspiracy of denial. Families fear the loss of status and their breadwinners. Assistants fear the loss of their jobs. Peers fear loss of coverage and an increased work load.

Your MSMS Committee to Assist Impaired Physicians is attempting to break this conspiracy of denial and motivate substance-abusing and disturbed physicians to get effective help before significant risk to the public or themselves has occurred.

Committee's procedures

How does the committee work? There are many types of referrals: by telephone call to MSMS headquarters (517-337-1351), by letters, or by verbal contact.

Doctor Smith is chairman of the MSMS Committee to Assist Impaired Physicians.

After the committee receives a referral, it sends a series of up to three letters. The first encourages the physician to contact the committee for an informal discussion of the referral information. If there is no response, a second letter discusses denial and strongly urges the recipient to contact the committee.

In the absence of a reply a third letter is sent. It states the committee's intent to contact the physician's hospital, office staff, family, and any other concerned parties to evaluate the possible problem without the physician's assistance, and then to dispatch an intervention team to discuss the information obtained.

We prefer to form intervention teams at the local level. Ideally, they are made up of a physician intimately aware of the same impairment, a mental health specialist, and a local peer. This team will arrange to call on the suspected impaired physician.

If it fails to establish rapport the "platooning" system implemented in Georgia is followed. New teams will be sent until the physician seeks treatment, is found to have no problem, or at least recognizes the committee means business. At no time will the committee become involved in treatment.

All information gathered by the committee is kept in strictest confidence. Minimal records are kept. They are carefully coded, and destroyed when no longer needed.

The committee serves only an advocate role. The enforcement arm of organized medicine functions well without help from us. If attempts to assist a physician fail, this apparatus will prevent harm to the public.

We feel this total separation of roles permits the committee to earn and deserve the confidence of the physicians needing our help.

The record

To date the MSMS Committee for Impaired Physicians has received 76 referrals. Fifty of these referrals were from hospitals or partnerships. Sixty referrals were for alcoholism, eight for drug addiction, six for psychosis, and two for senility.

Committee members are gratified with their record, as they have seen 52 physicians returned to practice. But so much more can be done. The committee is aggrieved with the 12 who attempted suicide, nine who were treatment failures, and three who left the state.

We have made a good beginning, but we need Michigan physicians' help. We need referrals. We need help in training, recruiting, and implementing local intervention teams. We need opportunities and help in educating our profession and those persons close to us.

Perhaps together we can see the day when no physician will lose a license, have a practice restricted or ruined because of a remediable, socially-stigmatized, health problem, or wish to end life. We may see the day when punitive sanctions will be reserved for unscrupulous physicians alone.

MSMS has history of concern

Concern for the impaired physician reaches deep into the Michigan State Medical Society.

As the reader can see by the articles in this special section, there is an active MSMS Committee to Assist the Impaired Physician. Its chairman, Russell F. Smith, MD, Brighton, describes the committee's activities in an article on the first page of this section.

MSMS action to find and assist physicians with alcohol and drug abuse problems extends back many years, as evidenced in the article in this section by Richard C. Bates, MD, Lansing, chairman for many years of the MSMS Committee on Drug and Alcohol Abuse.

The MSMS House of Delegates deals with the problem as it works to establish MSMS policy.

In November 1974, the MSMS Council, following the House's sentiments, adopted a statement of 11 general principles by which MSMS activity would be guided. (Please see accompanying article.)

In May, 1979, the MSMS House of Delegates reaffirmed its desire to help localities deal with problem physicians on the home level, and to "encourage all MDs in the state to look more perceptively and deeply at this problem so that a constructive, positive and not punitive action can be taken to guide our colleagues back to productive practices."

The House's Resolution #58, expressing many concerns, is in the hands of the MSMS Committee on Impaired Physicians for implementation. In his article Doctor Smith describes the committee's activity to carry out these new, more specific calls for action.

Here is the complete text of the resolveds portion of Resolution 79A-58, the most recent official MSMS statement on the impaired physician:

1979 resolution:

RESOLVED: That MSMS once again delineate the term "impaired or disabled physician" to describe a physician whose function is impaired by apparent illness; and be it further

RESOLVED: That the MSMS be prepared to provide to hospitals, medical societies, or individual constituents guidelines about the management of problems pertaining to the impaired physician; and be it further

RESOLVED: That the MSMS encourage hospitals and/or county medical societies to establish Impaired Physician Help Committees composed of highly regarded physicians in the community; and be it further

RESOLVED: That the MSMS encourage hospital medical staffs to establish a protocol for bringing a rehabilitated impaired physician back to the active staff; and be it further

RESOLVED: That the MSMS encourage all MDs in the state to look more perceptively and deeply at this problem so that a constructive, positive and not punitive action can be taken to guide our colleagues back to productive practices.

One Impaired Physician's Story

By M. J. M., MD

My contact with the Michigan State Medical Society Committee to Assist Impaired Physicians followed a long series of personal tragedies. I wish it had been much sooner when I think of the personal suffering that could have been saved.

My problems began when I was carried by the momentum of medical school and the doors that opened after into a medical specialty I found boring and unchallenging. Two attempts to establish a solo practice had to be abandoned because of my inability to get along with local physicians and gradual loss of patients, though I finally did join a group of physicians.

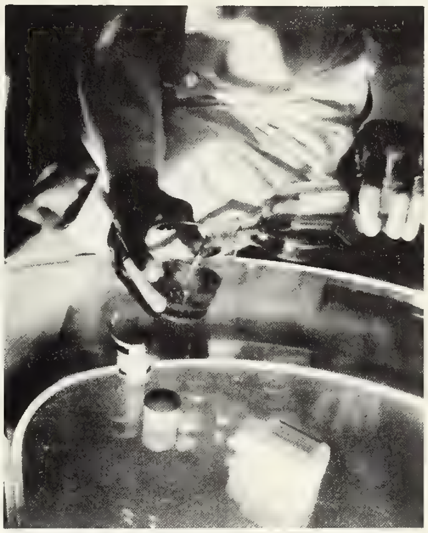
Each failure brought periods of deep depression. My world wouldn't stand still. People didn't measure up to my expectations. Things never went my way. My growing anger, frustrations, and depression paralyzed my ability to function.

I began to use office samples to make up the difference. I used Tofranil, Elivil, Dexamyl, etc., to get up during the day; Noludar, Librium, Valium to get down at night. Later I used prescription drugs discreetly to get the same effect. Eventually I graduated to alcohol because the effect was more immediate. When alcohol failed to keep me feeling well I even experimented with street drugs as well.

Finally I was so under the influence and my performance so poor that I became the subject of local gossip. Patients were asking to be transferred to other members of the group. The final disaster was my suspension from the hospital staff.

Committee contacted

I understand a member of the hospital ethics committee contacted the Impaired Physicians Committee. This committee member was worried since sometime earlier another physician expelled from the same hospital staff committed suicide. Imagine that!



Shortly afterward I was called by a committee member and agreed to see him since I had nothing else to do. We talked for some time and the committee member finally pointed out that my chronic emotional state and drug abuse had cost me enough. He told me that doctors just like me had been helped with similar problems.

My reaction was, "Nonsense, all I need is some rest, to move again where nobody knows me and I will be fine."

The committee member insisted that I was in no shape to help myself. He finally got me to agree to let him contact my partners, the hospital, and my family. In a week or so he had arranged a meeting in what was left of my office, with my family, a partner, and a hospital staff friend.

I was shocked, confused and amazed at what I heard I had done and the image they held of me. I resisted any advice, however, and continued to try to straighten myself out.

In the next few months I lost my family, my home, my practice and eventually was totally bankrupt financially, physically, and spiritually. The loss of everything I had worked for prompted a suicide attempt by drug overdose.

My office nurse called the Impaired Physician Committee member. He responded by arranging our emergency medical and psychiatric care, although I didn't have a dime and no insurance.

Following my acute care he helped me arrange voluntary commitment to a state hospital because I was broke and had no financial or personal resources.

Slowly I began to find myself in a drug-free environment, with the help of my therapist and lithium carbonate. I left the hospital well, and drug free except for my lithium.

My Impaired Physician Committee member maintained contact and on my release put me in touch with supports and contacts that allowed me to put a life back together.

Look forward

I now am in an academic research setting that provides the intellectually stimulating career I had been looking for for so long. I now look forward to each day on even terms without drugs, except for the lithium.

My MSMS Committee for Impaired Physicians intervenor proved to be a friend, a confidante, a support during crises, a sounding board, a door opener to committee resources. I did not have to face my life crisis alone and ill. My fellow doctors in the person of this representative showed they gave a damn. I had a reason to live, recover, and become active and productive again.

Physicians, heal thy colleagues

By Richard C. Bates, MD
Lansing

The rehabilitation of physicians addicted to alcohol and other drugs is finally catching hold. The Michigan State Medical Society was 13th of the more than 30 state medical societies which have, by now, set up committees to aid members with drinking and/or drugging problems that afflict one doctor in 10.

It's surprising that we have been so slow. A decade ago, industry followed the lead of such large corporations as DuPont, Allis Chalmers, AT&T, and Consolidated Edison. These major companies began in the early 1940's to prove that rehabilitation of alcoholic workers saved more money than did the previous system of firing them. In 1956 the AMA House of Delegates resolved that alcoholism was a treatable disease.

Still, until the last few years, the physician-alcoholic was ignored until his behavior affected his practice; then he was destroyed by seizure of his license.

At last, we are offering our sick colleagues the same path to recovery available to some factory workers for 30 years.

Approaches vary

In Georgia, that path is narrow, firm and rigidly circumscribed by a two-year contract wherein the physician agrees to start with a month of treatment at a center such as the 30-bed unit run by G. Douglas Talbott, MD. That's followed by a month of out-patient treatment, then by two months of working with other addicts and gradual resumption of practice under close supervision. Physicians who fail to cooperate risk being reported to the State Licensure Board.

In Oregon, the approach is much softer: A physician reported to have a problem is approached by experienced alcoholism counsellors and urged to get help. If he refuses, nothing further is done.

Regardless of the "tough" or the non-coercive approach, results are about the same — up to 50 percent rehabilitation — probably because, while the "soft" approach brings in larger numbers, it also has a higher failure rate. Our MSMS Committee to Assist the Impaired Physician, headed by Russell Smith, MD, along with similar committees in other states, is eclectic, using the soft approach first but standing ready to be coercive when patient welfare is threatened.

One of the largest problems yet to be solved is the reluctance of members of the physician's family to seek help. Despite attempts to educate our MSMS Auxiliary members, almost never do we see a physician coming into treatment because a spouse has asked for intervention.

Tragically, in a number of instances, wives have divorced their husbands without first trying the simple steps of calling the state medical society to enlist assistance from colleagues.

Office employees, too, have frequently been guilty of covering up their employer's behavior, thus jeopardizing patients and, in time, their own employment.

Still, as the word of rehabilitation gets around, there are an increasing number of referrals, largely from hospital administrators, malpractice lawyers and hospital staff members.

Treatment standard

As experience grows, the techniques for approaching these sick physicians are more skilled and refined, while agreements as to the requirements for a satisfactory treatment course is more uniform.

By now, authorities agree that supervision must extend for a minimum of two years; that physicians addicted to prescription drugs should surrender their BNDD license for good; that treatment should begin with hospitalization at some place like the Hazelden Foundation in Center City, Minnesota; the Mayo Clinic, or Doctor Talbott's hospital outside Atlanta, Georgia, and that best results follow continued attendance at AA, preferably with membership in the fellowship of International Doctors in Alcoholics Anonymous.

The Maryland State Medical Society is even loaning addicted physicians interest-free funds to support them during the early phases of rehabilitation: That's a degree of compassion unmatched even by labor unions and industry.

The addicted physician *is* a physician with a million-dollar education; he *is* a sick human being and in many cases he *can* be healed. Surely each of us knows at least one who has made it. In short order, now that we have overcome our punitive and primitive prejudices, there should be many more physicians coming forward for treatment.

Luke's Biblical injunction, "Physician, heal thyself" may now be amended to "Physicians, heal thy colleagues," particularly since Luke was apparently unaware of the adage that a physician who treats himself has a fool for a patient.

Doctor Bates is a contributing editor to* Medical Economics *and for many years was chairman of the MSMS Committee on Drug and Alcohol Abuse.

Doctor Bates

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Last chance to register for Public Affairs Conference

Government regulations, cost containment, and what doctors can do about them will be grist for the mill Oct. 24 at the Second Annual Public Affairs Conference, sponsored by the MSMS Committee on State Legislation and Regulations.

Registration is $15 for the day-long conference at Long's Convention Center in Lansing.

Congressman Dave Stockman of Michigan's Fourth District, a member of the Subcommittee on Health and Environment of the U.S. House Interstate and Foreign Commerce Committee, will open the program with a view of what's happening — and what might happen — on health care issues in Washington.

Walter McClure, PhD, vice-president and Director of Health Planning and Policy Development for the Minneapolis-based think tank, InterStudy, will follow the Congressman.

Oliver D. Grin, MD, Grand Rapids, who is the conference chairman, says, "We believe we have put together the broadest and deepest possible spectrum of thinking on the problems physicians are now facing."

The program:

9:00 a.m.	Registration	
9:30 a.m.	"Review, Preview and Prognostications from the Congress"	Congressman David Stockman
10:30 a.m.	"Getting Serious about Competitive Alternatives to Regulation"	Walter McClure, Ph.D., Vice-President and Director of Health Policy and Planning, InterStudy
1:30 p.m.	Panel: "How Some Individual Physicians Have Responded to the Challenges"	
	1:30 - "Cost Containment Legislation in Michigan"	W. E. Maldonado, MD, Chairman, MSMS Committee on State Legislation and Regulations
	1:50 - "Starting an IPA Type of HMO"	Frederick W. Van Duyne, MD, Chairman, MSMS Committee to Monitor HMO Development
	2:10 - "Working Within the Medicaid System"	David Siegel, MD, Chairman, MSMS Liaison Committee on Medicaid
	2:30 - Questions and Answers	
3:00 p.m.	"Summary and Foresight"	John R. Ylvisaker, MD, President-Elect, Michigan State Medical Society

Please return to:

1979 Public Affairs Conference
Michigan State Medical Society
P. O. Box 950
East Lansing, Michigan 48823

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Please check one

☐ Physician ☐ Other ____________

Registration Fee: $15 includes luncheon

Amount enclosed $ ________

Please make check payable to Michigan State Medical Society.

Here's final rundown on vital information about 1979 MSMS Annual Scientific Meeting

Doctor, have you made your plans yet for attendance at the 1979 MSMS Annual Scientific Meeting?

There still is time to reserve your place in the courses of your choice during the Nov. 13-14-15 event at the Hyatt Regency Dearborn.

There is so much the physician should know about this really extraordinary annual scientific meeting, one of the largest state society-sponsored continuing medical education events in the country.

COURSES: There are 56 half-day courses planned on a wide range of medical topics, to help the practicing physician improve care of patients on a day to day basis.

CREDITS: Each of the 56 courses offers three hours of Category I credit toward the AMA Physician Recognition Award and toward Michigan relicensure. A total of 18 Category I credits may be earned by the physician attending the entire Annual Scientific Meeting. In addition, all but one of the courses also offers American Academy of Family Physicians prescribed credit.

ACLS TRAINING: A special two-day course on advanced cardiac life support is scheduled Wednesday and Thursday, Nov. 14 and 15. The ACLS course is sponsored by the Michigan Chapter, American College of Emergency Physicians, and will award 16 Category I credits. In addition, candidates who successfully complete the testing according to American Hospital Association standards will be certified as providers in ACLS by the Michigan Heart Association. The course is limited to 48 physicians who have completed the basic cardiac life support course. The fee is $150.

FACULTY: 54 course directors have organized a faculty of approximately 210 outstanding academic and clinical experts to teach. The faculty members come from a total of 20 states, with Michigan's finest included. In many cases, the course directors and faculty members are the best-received from previous MSMS Annual Scientific Meetings.

FACILITIES: The always-excellent Hyatt Regency Dearborn hotel is the site of this year's Scientific Meeting. MSMS meeting rooms, registration desks and faculty headquarters all are located conveniently this year in the Regency Ballroom area on the first floor of the hotel, to the left of the entry and just past the hotel registration area.

The renovated Hyatt Regency this year offers a lovely pool and additional restaurants. The latter include the elegant La Rotisserie, db's nightclub and lounge, the lively Lobbibar, the revolving Rotunda lounge atop the hotel, the Prelude, Kafay's Place cafeteria and the new Julio and Sons gourmet restaurant.

Close by the Hyatt Regency are the outstanding historic exhibits of Greenfield Village and the Henry Ford Museum. The hotel itself is connected by an elevated "people mover" to the triple-level Fairlane shopping center. These attractions plus the nearness of the Detroit metropolitan area provide the possibilities of a mini-vacation for the doctor's spouse.

REGISTRATION: Physicians should register for the Annual Scientific Meeting by filling out the registration form and submitting the fees required. The registration form can be found in the Sept. 7 *Medigram*, the September *Michigan Medicine* and the first October *Medigram*. Copies are available, as well, from MSMS headquarters.

Registrations for the ACLS course were to be made by Oct. 1 and are limited to 48 physicians who have completed the basic CLS course.

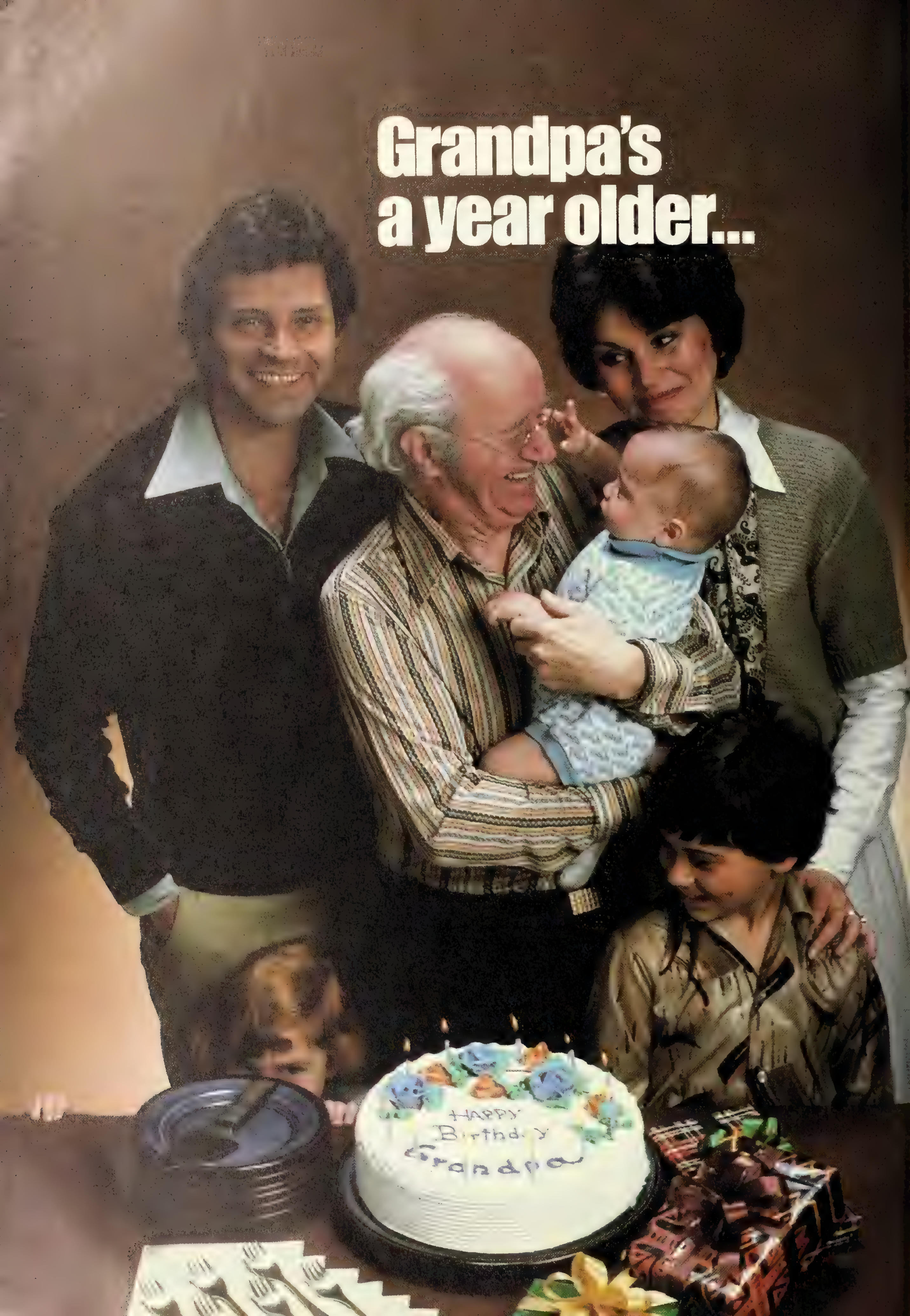
Physicians should make room reservations by Oct. 20 to take advantage of the special discount provided by the Hyatt.

FEES: The Annual Scientific Meeting courses cost $4 per credit hour, or $12 for each half-day course, for MSMS members. Non-members must pay $8 per credit hour, or $24 for each half-day course. The fee for the two-day ACLS course is $150, which includes an American Heart Association CLS text and other study materials.

LUNCHEON: The Hyatt will provide a luncheon each noon in the MSMS exhibition hall. The registration form asks physicians to indicate which days they would like to take advantage of this special arrangement.

SPECIAL EVENTS: Eleven specialty societies are scheduling business meetings, luncheons, receptions and dinners during the Annual Scientific Meeting. Interested physicians should contact their specialty society offices for tickets and details.

COMMITTEE IN CHARGE: The MSMS Annual Scientific Meeting Task Force is directing the organization of the 1979 MSMS Annual Scientific Meeting. Samuel M. McMahon, MD, Lansing, medical director, Ingham Medical Center, is chairman. Doctor McMahon's committee has worked over a year to plan the event, contacting the state's three medical schools and all its specialty societies to invite them to sponsor a course or two. The advisory committee falls under the aegis of the MSMS CME Programming Committee, led by Carl F. Hammerstrom, MD, Marquette.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and at greater risk from pneumococcal pneumonia

The risks rise sharply with the years—

Although pneumococcal pneumonia can occur at any age, it is often more serious for older patients. Elderly patients are at greater risk of developing severe bacteremic infection; hospitalization is often required and recovery may be prolonged. Your elderly patients with pneumococcal pneumonia also have a significantly higher mortality rate—despite antibiotic therapy.

Vaccination with PNEUMOVAX can significantly reduce the incidence, as well as the considerable economic cost, of pneumococcal pneumonia. For your elderly patients, it offers protection against a serious and frequently debilitating illness.

PNEUMOVAX is also useful for other patients at high risk: *persons having chronic physical conditions* such as chronic heart disease of any etiology, chronic broncho-pulmonary disease, chronic renal failure, diabetes mellitus, and other chronic metabolic disorders; *persons convalescing from severe disease; persons in chronic care facilities.*

PNEUMOVAX is contraindicated in pregnant females, children under two years of age, and in the presence of hypersensitivity to any component of the vaccine. *Adverse reactions* include local erythema and soreness at the injection site; low-grade fever occurs occasionally. *PNEUMOVAX will not immunize against capsular types of pneumococci other than those contained in the vaccine.* Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions.

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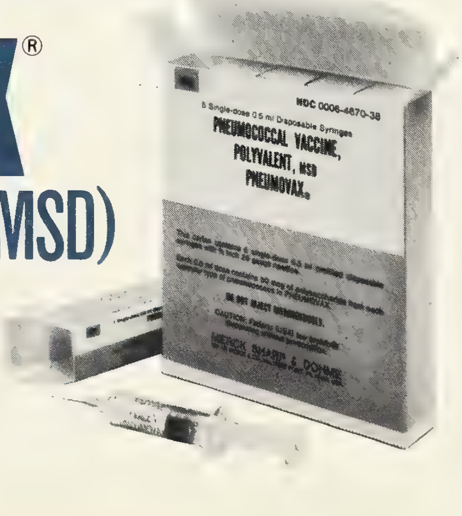
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Please see following page for summary of prescribing information.

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INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: *PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).*

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature	Pneumococcal Types													
U.S.	1	2	3	4	6	8	9	12	14	19	23	25	51	56
Danish	1	2	3	4	6A	8	9N	12F	14	19F	23F	25	7F	18C

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported.

Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. *DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.*

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

Single-Dose Prefilled Syringe
Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials
For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

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Teenage pregnancies, pharmacology topics of 1980 Maternal Health Conference

By Katie Brewbaker
MSMS staff

The "Art of the Science" — top drawer scientific information — is what the 1980 Michigan Conference on Maternal and Perinatal Health will offer registrants March 5-6 at the Hyatt Regency Dearborn.

The Conference Planning Committee, under the direction of co-chairmen Bruce A. Work, Jr., MD, and John W. Hallitt, MD, is putting together a program of nationally known speakers who will give in-depth presentations on subjects of major interest to obstetricians, gynecologists, pediatricians, neonatologists, family physicians, public health physicians, nurses, and support personnel.

New technology, such as ultrasonography, sensors, and monitoring will be covered on Wednesday morning. The afternoon will be devoted to an exploration of infections, with discussion of immunology, viral infections, lactation and bacterial infections.

New U-M chairman

Registrants will have an opportunity to hear the new chairman of the department of obstetrics and gynecology at the University of Michigan, Alan E. Beer, MD, when he addresses the assembly on "Bonding, Breast Feeding, and Bugs," and later on "Human Milk: Nature's Vaccine."

John L. Sever, MD, of the Center for Disease Control in Atlanta also will be there to help unravel the mystery of herpes.

Pharmacology is the umbrella under which such important topics as "Applied Anesthesiology: Complications of Pregnancy" and "Applied Anesthesiology: Low Risk Pregnancy" will be presented on Thursday morning.

This segment of the program also will give registrants up-to-date information on permissible and prohibitable drugs for the mother and the child she is carrying. Drugs discussed will be oral hypoglycemics, anticonvulsants, antibiotics and alcohol. Doctor Sever will be back to give physicians and nurses the latest data on hepatitis.

Early teen pregnancies

On Thursday afternoon a group of experts will inform registrants on a medical problem that is reaching epidemic proportions . . . adolescent pregnancy. The question will be how to handle the increasing number of patients in their early teens, both from a medical and sociological standpoint, what the recidivism rate is, and how to help break the chain.

Doctor Work and Doctor Hallitt continue to provide an outstanding program through the efforts of the Michigan State Medical Society and the co-sponsoring organizations: the Michigan Academy of Family Physicians; Michigan Chapter, American Academy of Pediatrics; Michigan Department of Public Health; Michigan Nurses Association; Michigan Section, Nurses Association, American College of Obstetricians and Gynecologists, District V; Michigan Section, American College of Obstetricians and Gynecologists; Michigan Society of Obstetricians and Gynecologists; Perinatal Association of Michigan; and Wayne County Medical Society.

Meetings

MSMS, AMA, MSMS/A and medical assistants

Oct. 16-17 — District Meeting, MSMS/A, at St. Joseph Hospital, Flint, contact: Mildred F. Carron, 2756 N. Wagner, Ann Arbor 48103.

Oct. 24 — MSMS Conference on State Legislation, at Long's Convention Center, Lansing, contact: Bruce Ambrose, MSMS headquarters.

Oct. 24-26 — 39th Annual AMA Congress on Occupational Health, cosponsored by the National Institute for Occupational Safety and Health, at University of North Carolina at Chapel Hill, contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn, Chicago, 60610.

Oct. 27-28 — Leadership Training Session, State of Michigan Branch, American Association of Medical Assistants, Flint Sheraton Hotel, contact: Mary Kehoe, 212 E. Broad St., Box 522, Linden, 48451.

Oct. 27 — Board Meeting, State of Michigan Branch, American Association of Medical Assistants, Flint Sheraton Hotel, contact: Mary Kehoe, 212 E. Broad St., Box 522, Linden, 48451.

Oct. 31 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 13-14-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters, 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 12-15, 1980 — AMA Winter Scientific Meeting, San Antonio, contact: Department of Scientific Assembly, AMA, 535 N. Dearborn St., Chicago, IL 60610.

Jan. 12, 1980 — 21st AMA Conference on the Medical Aspects of Sports, San Antonio, contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn St., Chicago, IL 60610.

Feb. 2-3, 1980 — Mid-Winter Seminar, State of Michigan Branch, American Association of Medical Assistants, Weber's Inn at Ann Arbor, contact: Frances Drawe, 2171 Medford, Apt. 33, Ann Arbor, 48104.

Mar. 9, 1980 – Board Meeting, State of Michigan Branch, American Association of Medical Assistants, MSMS headquarters, contact: Helen Schulte, MSMS headquarters.

April 17, 1980 — AMA 33rd National Conference on Rural Health, Sheraton-Boston, contact: Barbara Chapman 312/751-6604 or Gary Schwartz 312/751-6431.

April 17-19, 1980 — Annual Convention and House of Delegates, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn at Plymouth, contact: Margaret Broadwell, 16686 E. Eight Mile Rd., Detroit, 48205.

Other meetings

Oct. 23-25 — Michigan Society for Respiratory Therapy Annual Northern Michigan Clinical Seminar, Grand Hotel Mackinac Island, contact: Dave Roof, C.R.T.T., Respiratory Therapy Dept., Northern Michigan Hospital, Inc., Petoskey, MI 49770.

Oct. 30 — 67th Annual Conference, Michigan League for Human Services, Lansing Civic Center, contact: William Fairgrieve, 517/487-5436.

Nov. 8-9 — U of M Office of Continuing Medical Education Symposium on Diabetes, Howard Johnson's East, Flint, contact: Towsley Center for CME, 313/764-2287.

Jan. 17-18, 1980 — U of M Office of Continuing Medical Education Symposium on Diabetes, Towsley Center, Ann Arbor, contact: Towsley Center for CME, 313/764-2287.

Feb. 9-10, March 22-23, April 26-27, May 17-18, 1980 — Sexuality Training for Professionals, sponsored by Spectrum Psychological Services, at Michigan League, Ann Arbor, contact: Michael Brown, Spectrum Psychological Services, 6869 Marshall Rd., Dexter, 48130, 313/426-2334.

March 3-4, 1980 — U of M Office of Continuing Medical Education Symposium on Diabetes, Hospitality Motor Lodge, Grand Rapids, contact: Towsley Center for CME, 313/764-2287.

May 12-13, 1980 — U of M Office of Continuing Medical Education Symposium on Diabetes, Holiday Inn, Marquette, contact: Towsley Center for CME, 313/764-2287.

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Category I courses

***Michigan Medicine** each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Oct. 10, 17, 24 & 31, Rehabilitation Medicine for Psychiatrists. Location: Zuckerman Auditorium, Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., Detroit, 48235. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 13 - Dec. 8 (Saturdays), New Trends in Basic Care. Location: Holy Cross Hospital, Detroit. **Sponsor:** Holy Cross Hospital. **Cost:** $75. **Contact:** Medical Staff Secretary, Holy Cross Hospital, 4777 Outer Drive, Detroit 48234. **Approved for:** 20 hours of Category I credit.

Date: Oct. 18-19, New Aspects of Cardiovascular Diagnosis. Location: Benson Ford Education & Research Center. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** $130. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 18-19-20, Implant Surgery for Joints and Tendons in the Hand. Location: Blodgett Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand, Blodgett Memorial Medical Center. **Cost:** $250. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, SE, Grand Rapids 49506. 616/774-0440. **Approved for:** 19.5 Category I credits.

Date: Oct. 20-21, Nuclear Medicine in Oncology. Location: Hurley Medical Center, Flint. **Sponsor:** Central Chapter, Society of Nuclear Medicine and Hurley Medical Center. **Contact:** Central Chapter, Society of Nuclear Medicine, P.O. Box 160, Crystal Lake, IL 60014. **Approved for:** 11 hours of Category I Credit.

Date: Oct. 22-26, Family Practice Review. Location: Towsley Center, University of Michigan. **Sponsor:** U-M Office of Continuing Education. **Co-Sponsor:** Michigan Academy of Family Physicians. **For:** All interested physicians. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for: 32¾ hours of Category I Credit.**

Date: Oct. 26-27, Parenteral Nutrition. Location: Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** U-M Office of Continuing Education. **For:** Physicians, pharmacists, nurses and dietitians who manage patients on parenteral nutrition. **Cost:** $80. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 9¾ hours of Category I Credit.

Date: Oct. 31, Pulmonary Function Disorders: An Update. Location: E. W. Sparrow Hospital, Lansing. **Sponsor:** E. W. Sparrow Hospital Dept. of Family Practice. **For:** All interested physicians. **Cost:** No charge. **Contact:** Jean Machtel, CME Coordinator, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48909 517/487-2790. **Approved for:** 4 hours of Category I Credit.

(continued on page 545)

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital
Oakwood Hospital, Dearborn
Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma Agitated states Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result)
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored Titration of dose or discontinuance of Tenuate may be necessary
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride *Central Nervous System*. Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic* Urticaria, rash, ecchymosis, erythema, *Endocrine* impotence, changes in libido, gynecomastia, menstrual upset *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride). One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

Product Information as of April, 1976

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215 2. Hoekenga, M T , O'Dillon [Dillon], R H , and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride In, Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed , New York, Raven Press, 1978, pp 391-404

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Health planning update

By Dennis Paradis, Director
MSMS Physician/HSA Support Center

This is the second in a regular series of health planning features planned for *Michigan Medicine* by the MSMS Physician/HSA Support Center.

Federal health planning legislation passes congress

Senate Bill 544 has passed Congress and will be signed by President Carter. The bill extends the National Health Planning and Resource Development Act until 1982. It authorizes $1.037 billion for health planning for the next three years. Both houses of Congress passed the heavily-amended bill by a wide margin with little debate. An explanation of the changes brought about by the passage of SB 544 will be presented in a future issue.

Physician review of health systems plans imperative

One known change brought about by the passage of S. 544 is to place health planning on a triennial cycle. Since these HSP's will no longer be subject to yearly modifications, it is increasingly important for physicians to review them for appropriateness. The switch to a triennial planning cycle will also give the Health Systems Agencies (HSAs) more time to implement the recommended actions in the HSPs. The HSPs must be submitted to the Office of Health and Medical Affairs by November 1, 1979.

Approval delayed on first state health plan

Those in the know expect the State Health Plan (SHP), which is developed from the eight local HSPs, will be approved with modifications in November. As required by federal law, the SHP was approved by the Statewide Health Coordinating Council (SHCC). State law requires approval by the governor and the legislature for the state health plan to be recognized as a policy guideline for health planning in Michigan. The Legislature has allowed an extended period for serious review of the 750-page plan, through an amendment offered by Sen. Edward Pierce, MD.

Overweight may not always be simple... complications can develop.*

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In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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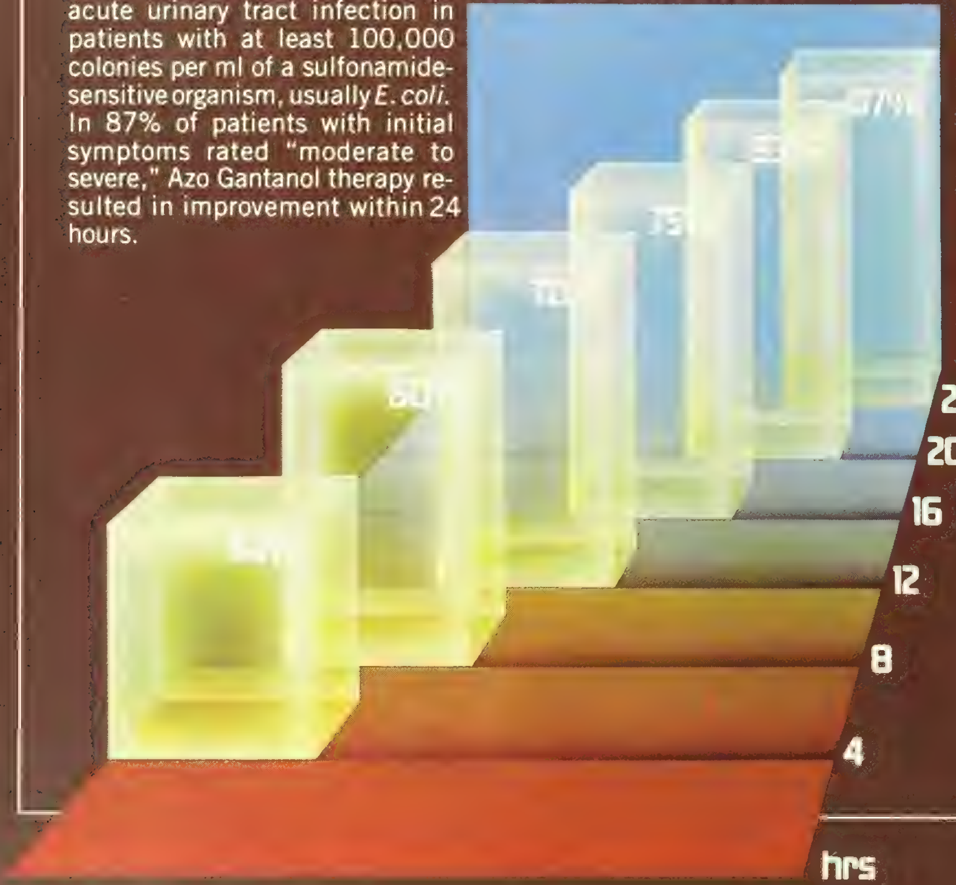

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uct information, a summary of which follows
Indications: In adults, urinary tract infection
complicated by pain (primarily pyelonephriti
pyelitis and cystitis) due to susceptible orga
(usually *E. coli, Klebsiella-Aerobacter, Stap*
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quently, *Proteus vulgaris*) in the absence of
obstructive uropathy or foreign bodies. **Note**
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tests with bacteriologic and clinical respons
aminobenzoic acid to follow-up culture medi
increasing frequency of resistant organisms
the usefulness of antibacterials including su
fonamides. Measure sulfonamide blood leve
variations may occur; 20 mg/100 ml should
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fonamide hypersensitivity; pregnancy at term
during nursing period; because Azo Gantano
tains phenazopyridine hydrochloride it is co
dicated in glomerulonephritis, severe hepati
uremia, and pyelonephritis of pregnancy wit
disturbances.

Warnings: Safety during pregnancy not estab
Deaths from hypersensitivity reactions, agra
tosis, aplastic anemia and other blood dyscr
have been reported and early clinical signs (
throat, fever, pallor, purpura or jaundice) ma
dicate serious blood disorders. Frequent CB
urinalysis with microscopic examination are
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Precautions: Use cautiously in patients with
paired renal or hepatic function, severe alle
bronchial asthma; in glucose-6-phosphate
dehydrogenase-deficient individuals in whom
dose-related hemolysis may occur. Maintain
adequate fluid intake to prevent crystalluria
stone formation.

Adverse Reactions: *Blood dyscrasias* (agran-
ulocytosis, aplastic anemia, thrombocytope
leukopenia, hemolytic anemia, purpura, hyp
thrombinemia and methemoglobinemia); *all*
reactions (erythema multiforme, skin erupti
Stevens-Johnson syndrome, epidermal necr
urticaria, serum sickness, pruritus, exfoliati
dermatitis, anaphylactoid reactions, periorb
edema, conjunctival and scleral injection, p
sensitization, arthralgia and allergic myocar
G.I. reactions (nausea, emesis, abdominal
hepatitis, diarrhea, anorexia, pancreatitis a
stomatitis); *CNS reactions* (headache, perip
neuritis, mental depression, convulsions, a
hallucinations, tinnitus, vertigo and insomn
miscellaneous reactions (drug fever, chills,
nephrosis with oliguria and anuria, periarte
nodosa and L. E. phenomenon). Due to cert
chemical similarities with some goitrogens,
uretics (acetazolamide, thiazides) and oral
glycemic agents, sulfonamides have caused
instances of goiter production, diuresis and
glycemia. Cross-sensitivity with these agent
exist.

Dosage: Azo Gantanol is intended for the ac
painful phase of urinary tract infections. *Us*
adult dosage: 2 Gm (4 tabs) initially, then 1
(2 tabs) B.I.D. for up to 3 days. If pain pers
causes other than infection should be sough
After relief of pain has been obtained, conti
treatment with Gantanol (sulfamethoxazole)
be considered.

NOTE: Patients should be told that the oran
dye (phenazopyridine HCl) will color the uri

Supplied: Tablets, red, film-coated, each co
ing 0.5 Gm sulfamethoxazole and 100 mg
phenazopyridine HCl—bottles of 100 and 5

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CATEGORY I/*continued*

Date: Nov. 1, MSU Family Practice Research Day. Location: University Club, Lansing. **Sponsor:** Department of Family Practice, MSU College of Human Medicine. **For:** Family Physicians. **Cost:** $30. **Contact:** Douglas McKeag, MD, Department of Family Practice, MSU College of Human Medicine, B-100 Clinical Center, East Lansing 48824. 517/353-0850. **Approved for:** 8 hours of Category I Credit.

Date: Nov. 1-3, Interqual Seminar on Malpractice Liability Control Techniques. Location: Detroit. **Sponsor:** Interqual. **For:** Administrators, Medical Staff Officers, Risk Managers, Board Members, Insurers, Attorneys, Nursing Directors, and all others associated with risk minimization efforts. **Cost:** $375. **Contact:** InterQual, 740 North Rush St., Chicago, 60611, 312/751-2327. **Approved for:** 15 hours of Category I Credit.

Date: Nov. 2, New Trends In Cardiovascular Disease. Location: Borgess Hospital, Kalamazoo. **Sponsor:** Committee for Continuing Education in the Field of Cardiology. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Cardiologists and other concerned medical practitioners. **Cost:** $60.00. **Contact:** E. Leguizamon, MD, 1717 Shaffer Road, Borgess Professional Bldg., North — Suite 106, Kalamazoo, 49001. **Approved for:** 6½ hours of Category I Credit.

Date: Nov. 2, Legal and Ethical Aspects of Treatment for the Critically or Terminally Ill Patient. Location: Detroit Plaza Hotel. **Sponsor:** American Society of Law and Medicine, Committee on Medico-Legal Problems, The State Bar of Michigan, Michigan Association of Osteopathic Physicians and Surgeons, Michigan Hospital Association, Michigan League of Nursing, Michigan Society of Hospital Attorneys, Michigan Nurses Association and Michigan State Medical Society. **Cost:** $40. **Contact:** American Society of Law and Medicine, 520 Commonwealth Ave., Boston, 02215 (617/262-4990.) **Approved for:** 6 hours of Category I Credit.

Date: Nov. 3, Acute & Chronic Orthopeadics for Primary Care Physicians. Location: Benson Ford Education & Research Center. **Sponsor:** Henry Ford Hospital. **For:** Primary care physicians. **Cost:** $70. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 5-9, Principles of Milieu Practice: Working With the Elderly in Treatment Settings. Location: University of Michigan, Ann Arbor. **Sponsor:** Institute of Gerontology. **Cost:** $140. **Contact:** Dorothy Coons, Institute of Gerontology, U-M, 520 E. Liberty Street, Ann Arbor. 313/763-4101. **Approved for:** 30 hours of Category I credit.

Date: Nov. 9-10, Twenty-Seventh Annual Symposium on Trauma. Location: Harper Hospital, Detroit. **Sponsor:** Department of Surgery, Wayne State University and the Michigan Committee on Trauma of the American College of Emergency Physicians. **For:** All interested physicians. **Cost:** $60.00. **Contact:** Charles E. Lucas, MD, Program Chairman, Wayne State University, Department of Surgery, 313/224-0736. **Approved for:** 9 hours of Category I credit.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 28, Updating Core Knowledge in General Surgery. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Dec. 8, Seminar on Diagnostic Problems in Gynecologics, Soft Tissue, and Male Genitourinary Tract Pathology. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Dr. T. A. Reyman, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, Michigan or Dr. John G. Batsakis, Department of Pathology, University of Michigan Medical Center, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 9, 16, 23 & 30, 1980, Liaison Psychiatry. Location: Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., Detroit 48235. **Approved for:** 6 hours of Category I Credit.

Date: Jan. 16, 1980, Hypertension. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236. (313/343-4000). **Approved for:** 8 hours of Category I credit.

Date: Feb. 13, 20, 27 and March 5, 12 & 19, 1980, Child Development. Location: Auditorium, Mount Carmel Mercy Hospital, Detroit. **Sponsor:** Mt. Carmel Mercy Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., 48235. **Approved for:** 9 hours of Category I Credit.

Date: March 19, 1980, Infectious Diseases in Obstetrics and Gynecology. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: May 21, 1980, Medical Therapy in Family Practice. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

MSMS co-sponsoring Nov. 2 meeting on ethics of medical care

Troubling legal and ethical questions regarding the care of critically- and terminally-ill patients will be the subject of a conference co-sponsored by MSMS Nov. 2 at the Detroit Plaza Hotel.

The conference also is being sponsored by the American Society of Law and Medicine, the Committee on Medicolegal Problems of the State Bar of Michigan, the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Hospital Association, the Michigan League for Nursing, Michigan Nurses Association and the Michigan Society of Hospital Attorneys.

MSMS has designated the conference as CME activity meeting the criteria for six Category I credit hours toward the AMA Physicians Recognition Award and toward relicensure by the Michigan Board of Medicine.

Attendance is limited and advance registration is suggested. The registration fee is $40 for MSMS members. A block of specially priced rooms has been set aside for Nov. 1 and reservations should be made directly with the hotel.

Conference reservations should be made by sending name, title, organization, mailing address and check to American Society of Law and Medicine, 520 Commonwealth Ave., Boston, MA 02215.

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The problem went critical with plans to consolidate these facilities and to add a new unit with space included for a mental health center.

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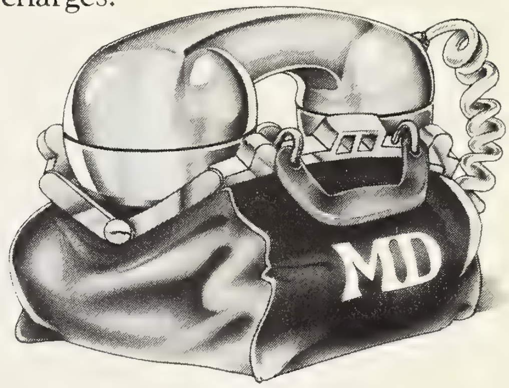

Calls follow doctors wherever they go.

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Michigan Bell

Need some creative solutions to office practice problems? Try your PSG

By David L. Laytner, PhD
Southfield

We are living in a problem-solving society, and it is often difficult for us to realize that some problems cannot be easily resolved.

Considering how the business side of medical practice has become increasingly sophisticated, one would assume the various business systems accompanying that sophistication are able to cope with any daily problem arising in the practice setting. One quick perusal, of course, tells us that this is simply not the case.

In his somewhat whimsical book *Systemantics*, John Gall of the University of Michigan elaborates upon an interesting observation: systems rarely accomplish their intended ends; in fact, they often become ends unto themselves.

Systems become masters

A study of your office procedures may reveal some unfortunate examples of the above theorem. Not only do systems become self-justifying and self-perpetuating; they often become masters of the very problems they were intended to solve, perpetuating the problems, too! They force people to become tools of the system, rather than the other way around.

If a physician alters his or her practice style to conform to a given appointment scheduling system, he or she has become the proverbial dog being wagged by its tail. The very appointment system designed to help control patient mix and patient flow, has forced the doctor to become the kind of physician demanded by the rigors of the practice. The MD no longer is the master of the system; he or she is, in fact, its slave.

MEDICAL RECORDS

If a doctor repeatedly and voluntarily interrupts the practice day to take a variety of telephone calls, urgent or not, medical or not, he or she is being bested by *two* of these systems. The telephone system designed to smooth communication between doctor and patients is instead dictating its own terms to the doctor, and the triage system designed to separate genuine urgencies from more mundane calls is having exactly the opposite effect.

Moreover, the physician may well be too close to the problem to identify it; rather, he or she is likely to misread the situation, and treat the symptom rather than the disease.

The doctor may diagnose the problem as one of patient load, feeling that there simply are not enough hours in one day to practice the kind of medicine he or she likes.

In fact, however, this is *not* the case. The system is forcing the doctor to practice its kinds of medicine, the practice style that best conforms to its own strictures and rigid limitations.

Physicians must be *creative* in their practices! They must examine their internal systems to determine exactly who or what is at the helm.

On automatic pilot?

If your practice seems to be on automatic pilot and you merely one of the many passengers, including patients and staff, it is time to take a long, hard look at internal operating systems and procedures.

If the physician is not the one controlling the operation of his or her own practice, he or she had better take immediate steps to do so!

The new MSMS/Physicians Service Group, Inc., is already busy helping Michigan physicians find creative solutions to their office practice problems. The PSG stands ready to help in a myriad of ways.

Won't you please take advantage of this help geared directly to MSMS members' needs? Telephone 517/337-1351 for assistance.

(more on page 550)

Doctor Laytner is practice management consultant, MSMS/Physician Service Group, and is president of a management consulting firm, Amerimed, Ltd., of Southfield.

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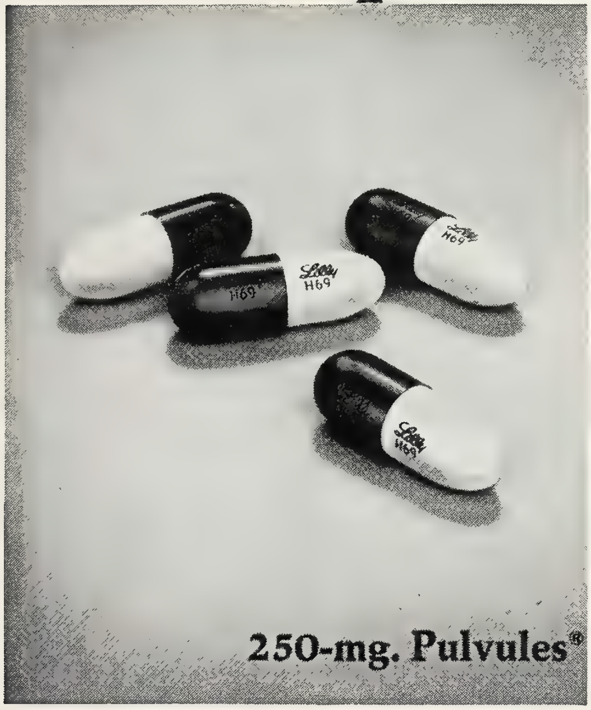

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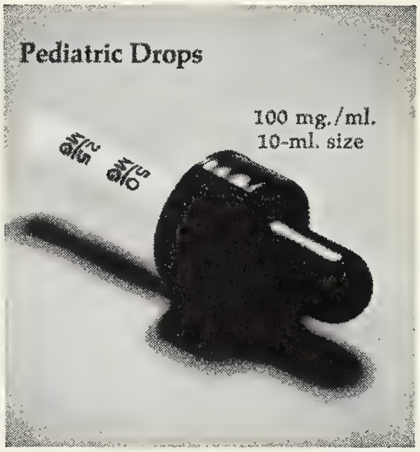

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Shades of the 30's: Physicians soon may have to look for patients

By R. Timothy Hogan, CPBC
Ann Arbor

Chances are you've never had to worry about building a practice. A generation of physicians has grown accustomed to an abundant supply of patients which seemed inexhaustible.

The new doctor has looked forward to having a substantial work load within a relatively short time, and usually has achieved it.

The established physician has enjoyed a largely self-renewing practice in which new faces replaced the old with little effort on his part.

The practitioner's biggest problem has been coping with the flood of patients without working himself to death in the process.

The first signs that this familiar situation might change were the concerted efforts of government, organized medicine, and training institutions to increase the number of doctors. The years between 1950 and 1975 saw the establishment of 35 new medical schools, expanding the total of new graduates 121 percent by the end of the period. During the same two and a half decades, newly licensed physicians (including foreign medical graduates) increased by 180 percent, and the number of doctors per 100,000 population rose from 141 to 181 — a growth of 28 percent.

Doctor surplus

The steady increase in physician supply, combined with a stabilizing of population growth, has significantly altered the much publicized doctor shortage. Authorities are beginning to suggest that we are passing from a period of doctor shortage and maldistribution to one of surplus, from a provider's market in medical services to a consumer's market.

The implications of the change are profound and will become crucial as the ratio of physicians to population continues to increase — an increase which has been variously projected at 28 percent to 40 percent over the next 13 years. The shift from doctor shortage to adequate or surplus doctor supply will bring a corollary shift from patient abundance to patient scarcity. The result will be a new practice environment with a new competition for patients.

Along the way an ever-growing number of physicians will have to reassess their practice philosophies, work habits, and attitudes. Questions which were familiar to doctors who practiced in the 1930's will again become important. "How can I attract new patients? What can I do to keep the ones I already have? Are there ethical ways to make my availability known?"

In short, the principal management question in the future for many if not most physicians is likely to be, "How can I build and maintain my practice?"

Let's look more closely at the problem of practice building, and at the kind of physician who is likely to flourish in a competitive atmosphere.

Ask patients what they want from a doctor and most will probably reply, "good medical care." Few patients, however, are capable of evaluating their physician's technical expertise. They judge his performance or lack of it by unscientific but nonetheless tangible criteria. Among the most important are affability and availability.

Attracting patients

The affable doctor — the doctor who is loved by his patients because he provides the kind of warm care they want when they are ill, who effectively communicates his concern

(continued on page 552)

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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for their welfare — is likely to have the edge when it comes to attracting and holding patients. The physician with little personal warmth (though he may have great technical ability), who is uncommunicative, or unresponsive, will find himself at a disadvantage.

One doctor's style is not another's, and the affable physician needn't be a charm school graduate to convey the sense of being a caring individual. Some doctors are affable and blunt; others are affable and diplomatic.

Nor is there a list of devices or gimmicks that will infallibly win the patient's esteem. Some doctors send thank-you notes to referring patients with the same regularity they do to referring physicians. Their patients like them for it. Others never forget a patient's upcoming birthday. Their patients like them for it. Others do neither and their patients still like them.

The absolute minimum is probably an ungrudging willingness to answer questions and explain the treatment rationale to the fullest extent compatible with the patient's understanding and the circumstances of the case. Anything less will give the impression the doctor is too busy to care — the most unaffable indicator of them all.

The role of the office staff in successful practice building should not be overlooked. The too protective nurse whose chief concern is guarding the doctor's time, the discourteous medical assistant, and the overeager receptionist who wants to clear up an outstanding balance have probably lost as many patients as the unaffable physician. In an important sense, the office personnel are extensions of the doctor. Their failings will inevitably reflect on him, and their good performances will enhance his own.

Availability important

Closely associated in the patient's mind with the physician's affability is his availability. The doctor who is difficult to reach when patients need him (or think they do) is in danger of losing patients to physicians who are more accessible.

The key factors in availability are the appointment schedule and the telephone. The proper use of each is a topic in itself, and both are subjects for lively debate.

Suffice it to say that years of surveys have shown excessive waits in the doctor's office to rank near the top of patients' complaints about their physicians. Lengthy periods by the telephone without knowing when the physician will return a call are less frequently mentioned but equally alienating when encountered. Practices with reputations for either of these phenomena should expect problems in stemming patient loss or attracting new patients.

Office hours are a component of physician availability which has been neglected in recent years. Few doctors have the evening and weekend hours which working patients find especially attractive. The physician who can see patients at these times will gain a competitive advantage, and the unaffable, uncommunicative physician may well have to do so.

But availability in itself will not build a practice if the community is not sufficiently aware of the physician's existence. The sources of new patients are many, and patients the doctor already has are among the best. Their response to the doctor who is affable and available will often include spreading the word to family, friends, and relatives. A positive comment, such as "I'll be glad to take a look at him," is the only reaction needed.

cartoons by JOHNS

" YOUR MALPRACTICE INSURANCE ? "

Referrals key

Referring physicians will be encouraged by prompt acknowledgement of each referral, followed by a report of findings. The physician who wants to develop his practice should not neglect the opportunities the hospital offers for getting to know more of his colleagues. A few minutes daily chat in the doctor's lounge, or service on one of the hospital committees (never overstocked with volunteers), will add to his referral sources, as will frequent attendance at medical society meetings and participation in its activities.

The list of professionals and businessmen the physician regularly encounters in the course of his practice is longer than he may realize — banker, attorney, management consultant, accountant, tax service, landlord, pharmacist, stockbroker, drug and insurance salesmen, office equipment dealers, even the mailman. Each has contact with a wide circle of his own, and each is a potential referral source.

A sampling of the scores of activities sponsored by local service, school, church, civic, and cultural organizations will further enlarge the physician's reservoir of referrals.

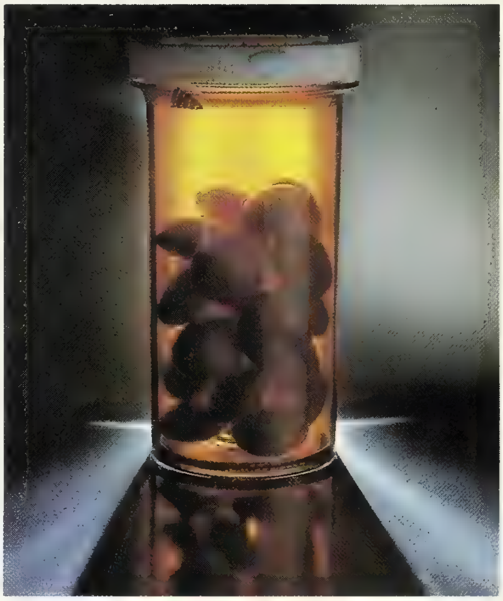
Advertising is still largely untested as a path to new patients, but a period of intensified competition is likely to produce experiments in this direction which go beyond the presently accepted listings in medical society, hospital, telephone and physician directories.

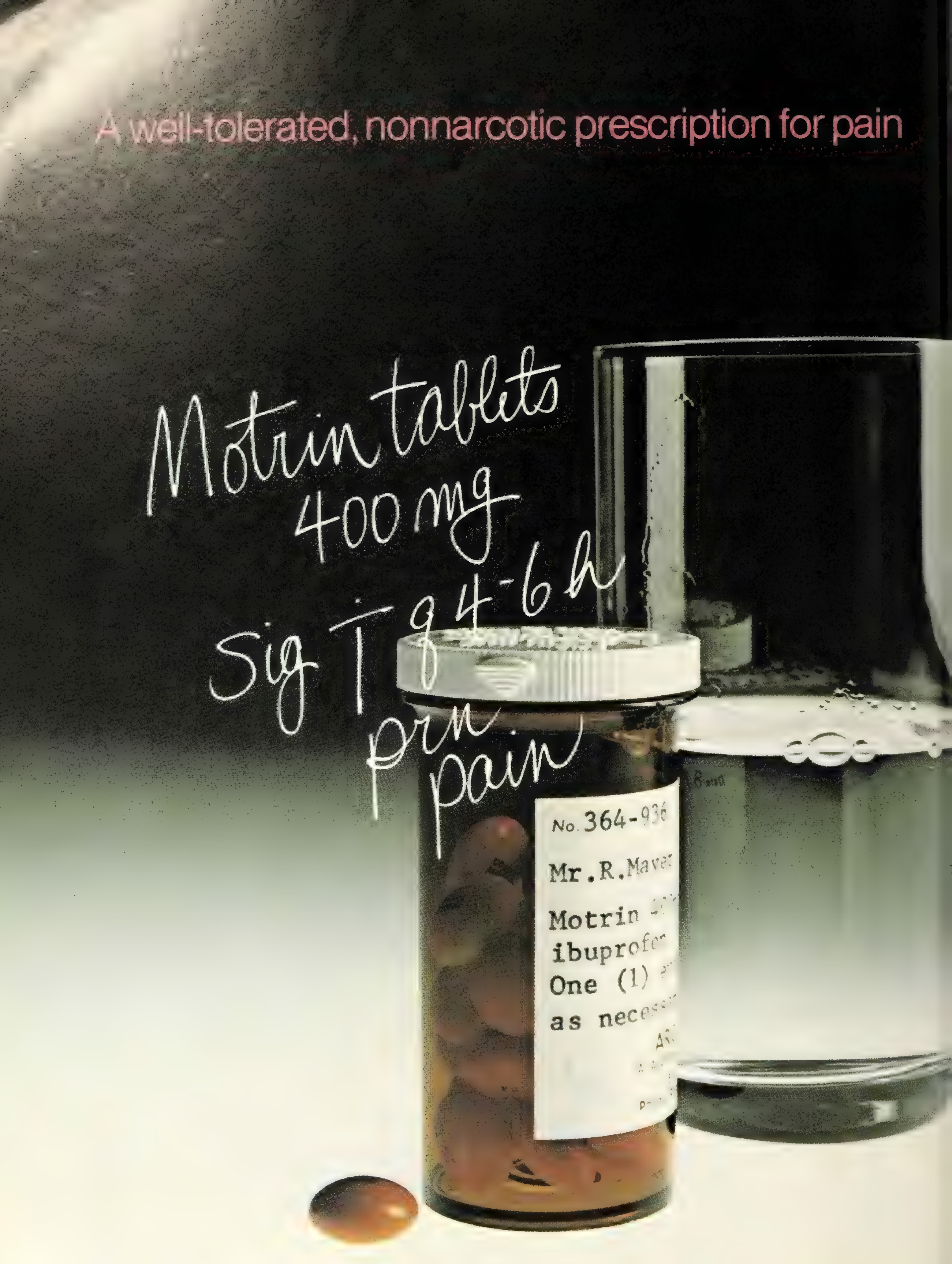
The shortage and maldistribution of physicians is still with us, and in some localities and specialties is likely to persist for an indefinite period. Other practitioners, however, are beginning to experience the effects of greatly increased physician supply. As supply continues to grow, competition for patients will intensify and lend a renewed importance to the problem of developing and maintaining a medical practice.

(References are available from the author.)

The Upjohn Company announces a new indication for Motrin®

(ibuprofen)

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Motrin now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

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- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

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Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

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A recent Michigan lawsuit dealing with the responsibilities of supervising physicians for residents made the front page of a recent AMA *Citation* newsletter. The *Citation* is a medicolegal digest for physicians. The newsletter's summary of the case is reprinted below:

Supervising physicians liable for improper tubal ligation by resident

Two supervising physicians were liable for the negligence of a resident who failed to perform a tubal ligation properly, a Michigan appellate court ruled.

A few months after undergoing a tubal ligation, the patient discovered that she was pregnant. The preexisting health problems that had led to her decision to undergo sterilization forced her to accede to a therapeutic abortion and ligation of the remaining fallopian tube. Subsequently, a hysterectomy was also performed.

After a trial, a jury returned a verdict in favor of the patient for $100,000. Since the hospital had paid $40,000 as a settlement prior to trial, judgment for $60,000 was entered against the two physicians, who specialized in obstetrics and gynecology.

On appeal, the physicians alleged that the trial court erred in admitting testimony of the patient's expert witness. He was a board-certified specialist in obstetrics and gynecology. The two physicians claimed that since they did not actually perform the surgery but were merely responsible for supervising the resident who did, they were not practicing their specialty and should not be held to the national standard of specialists. The expert testified that he was not familiar with the procedures in the hospital, a teaching institution.

The appellate court said that the two physicians were engaged in the practice of their specialty in treating the patient. The locality rule did not apply to specialists teaching their specialty.

Failure to take reasonable care in ascertaining that the surgery was competently performed rendered them liable for damages, the court said. Even though the expert witness was not familiar with procedures at the hospital, he was qualified to testify as an expert witness on the applicable standard of care, the court concluded. — *McCullough v. Hutzel Hospital*, 276 N.W.2d 569 (Mich. Ct. of App., Jan. 17, 1979)

Countersuits virtually dead in New York

MSMS Legal Counsel A. Stewart Kerr draws MSMS members' attention to a recent New York Appellate Court (the highest court in that state) ruling which, says Mr. Kerr, "sounds the death-knell of countersuits in New York."

The ruling is detailed, along with the circumstances of the case, in the July 9 issue of *Medical Economics.*

Author of the article in that issue comments: "it looks as though doctors probably can forget about countersuits in this bell-wether state altogether," as a result of the case's outcome.

Patients who sue just might be immune to countersuit as a result of the case, says the magazine in its headline.

"The movement to countersue lawyers who bring unfounded medical malpractice suits has had a number of setbacks lately in state courts. That's especially true in New York, where the highest court not long ago ruled in effect that lawyers are liable for damages only to their clients.

"Now the same court has ruled against a doctor in a case that could determine whether patients, too, are immune to countersuits for malicious prosecution and intentional damage without justification."

The physician involved went to the highest court possible in his state to attempt to sue his patient who he felt had brought suit against him maliciously and on false allegations.

His lawyer reasoned that "this state should go on record as telling patients they should not sue doctors for malpractice based on allegations they know to be untrue."

The doctor was turned back by the high court, however, and thus never had the chance to try his case against his patient on its merits. Full details appear in the article beginning on page 29 of the July 9 issue of *Medical Economics.*

MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

Doctor Holly

FOR: Leland E. Holly, II, MD
President, Physician Service Group, Inc.

"Why do so many physicians have a problem with payments that are long overdue from patients?"

Part of the blame for this problem belongs to the patterns of a particular medical practice. Often the patient believes he or she is not expected to pay until some point in the future. The more a patient can be encouraged to pay the fee before leaving the doctor's office, the better the chances that payment will indeed be received. This also will decrease the expense involved in billing and rebilling patients. The physician needs to train the office staff to present the bill in a manner that suggests immediate payment rather than after billing.

Doctor Gascoigne

FOR: Richard H. Gascoigne, MD
Chairman, MSMS Liaison Committee
with Michigan Department of Public Health

"Does MSMS have a stand on environmental pollution? If so, what is it?"

Statements on environmental pollution have been made several times during the last 15 years by the MSMS Council and House of Delegates, the major policy-making bodies of the state society. In 1966, The Council endorsed "The principle of reasonable and scientific study directed toward the sensible control of the major problems of air and water pollution."

In 1970, The Council strongly backed efforts to improve the environment, supported all agencies charged with the control of environmental pollution, and said, "We believe any legal means should be utilized to obtain maximum compliance with the statutes protecting us from undue water pollution, air contamination, improper solid waste disposal and noise pollution."

Most recently, in 1977, the MSMS House of Delegates opposed the use of lands in northern Michigan for the disposal of nuclear wastes, "until it is clearly demonstrated that such disposal of nuclear waste would not be deleterious to the people or to the environment of Michigan."

Doctor Kuiper

FOR: Donald H. Kuiper, MD, Lansing
Michigan Board of Medicine

"Why are there no rules or regulations yet for physicians' assistants?"

Frankly, the situation is a real political mess. The Michigan Boards of Medicine and Osteopathic Medicine have agreed upon a set of rules and regulations, which they are mandated by law to promulgate. Our proposals, however, were rejected July 11 by the legislature's Joint Rules Committee. The PAs and the Health Occupations Council testified before the Joint Rules Committee that our proposals are too restrictive. The Joint Committee must okay all proposed rules and regulations before they go through the statute-making process, but it has, in effect, sent our proposed PA regulations back to us. We're at a logjam.

I would urge individual Michigan physicians to contact their legislators and ask them to act favorably on these proposed rules and regulations. They were hammered out over a year and a half's worth of efforts by osteopathic physicians and MDs.

And right now, it's bad for the state not to have the rules. Physicians' assistants now are getting interim approval to practice with no screening of their qualifications. They simply need to have been a physician's assistant prior to 1977, when they were officially recognized and permitted to practice by state law.

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This is the fifth in a series of practical guides developed by the MSMS Task Force on Medical Care Costs to assist local hospital medical staffs in developing cost containment strategies and programs. The Task Force was authorized by the 1977 House of Delegates to develop methods of practice to assist in containing the costs of health care without compromising quality medical care. While the Task Force is mindful of the complexities involved in controlling the increase of medical care costs, it believes that physicians can attack the problem by continuing to initiate and support cost-savings activities at a local level. Guides 1 and 2 were printed in the June, 1978 issue of *Michigan Medicine* while Guides 3 and 4 appeared in the November 1978 issue.

Practical Guide #5: Cost Savings in Surgery

Description:

A detailed study of surgical procedures can result in identification of areas where cost savings can be made without affecting the quality of care.

Objectives:

The objectives of procedural evaluation studies are:

A. To encourage local medical staffs and hospital administrations to re-examine and re-evaluate tests, services, procedures, and materials used in the care of surgical patients.

B. To use the results of the study to determine where savings can be made.

Methodology:

A. Medical staffs should review policies and procedures covering the performance of surgery, and pre-operative, operative, and post-operative care. Special attention should be given to the following:

1. Can length of stay in the hospital be shortened in selected cases?
2. Can more surgical procedures be performed on an out-patient basis?
3. Can pre-admission testing be utilized more frequently?
4. Can suitable intermediate care be developed and utilized so some patients can be transferred sooner from special care areas?

B. Hospitals should be encouraged to review purchasing practices for surgical supplies.

C. Individual surgeons should re-examine their standing orders for surgical patients in the light of new information regarding the necessity of some x-ray and laboratory tests.

D. Physicians should consider substituting appropriately trained non-physician surgical assistants in the operating room and in post-operative care.

E. Everyone involved in the care of surgical patients should be made aware of the charge to the patient for each item used or service rendered, to help eliminate possible wasteful practices.

MEMBERS OF THE TASK FORCE ON MEDICAL CARE COSTS ARE: R. Jack Chase, MD, Chairman, Grand Rapids; Robert W. Black, MD, Detroit; Robert H. Hamburg, MD, Detroit; Ronald L. Krome, MD, Detroit; John H. Libcke, MD, Pontiac; Gerald H. Mandell, MD, Detroit; Sheldon F. Markel, MD, Ann Arbor; James E. McGillicuddy, MD, Lansing; E. James Potchen, MD, East Lansing; James A. Read, MD, Birmingham; Frederick W. VanDuyne, MD, Flint; Charles R. Zimont, MD, Constantine; and Louis E. Heideman, MD, Birmingham, ex officio.

Editor's note: To assist hospital medical staffs in developing their own surgical cost-saving programs, copies of a model study of selected cardiovascular procedures conducted at Butterworth Hospital, Grand Rapids, are available from Richard Campau at MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823.

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Psychiatric knowledge and skills integral parts of complete care

Doctor Tourkow

By Lawrence P. Tourkow, MD
Huntington Woods

As psychiatric knowledge and efficacy of treatment techniques increase remarkably, the emphasis is shifting away from the early preoccupation with the derivatives of drives and impulses which motivate human behavior in a general way.

Now we are far more concerned with how the human mind works to maintain internal harmony and to adapt to the requirements of the external environment, functions accorded to the ego.

Especially for those of us working in close collaboration with our medical colleagues in hospitals and clinics, the focus is on the ego operations of the patients who comprise the bulk of the average physician's practice and who do not offer histories suggestive of gross psychopathology.

Nevertheless, these psychiatrically "normal" patients all have to deal with the psychic stresses associated with the fear or reality of physical illness, hospitalization, surgery, and even the physiologic states of pregnancy and parturition.

As a result of unavoidable stresses, human beings go through a series of life crises from early childhood on. If they can master a life crisis, they can take a step toward greater maturity. If the crisis overwhelms the individual, he or she regresses and impedes maturation.

This proposition holds true throughout our lives though it is most dramatically observed in children. The individual's ability to handle a life crisis depends on four factors: 1) the severity of the stress, 2) the personality resources of the individual, 3) the alternatives furnished by the environment, and 4) the sources of support available to the individual.

Physician must help

The practice of good medicine requires that the physician help the patient deal successfully with life crises as an integral part of treating the patient. To do this the physician must be able to discern: 1) that the patient is under stress, 2) how he is attempting to cope, 3) how successful are his coping mechanisms, and 4) what price coping is exacting from emotional comfort.

From the foregoing, the physician can determine whether the patient is doing well enough or whether psychiatric intervention would be helpful.

The primary care physician can intervene as indicated if he or she has the requisite knowledge and skill. The consulting psychiatrist may work directly with the patient, or the primary care physician may confer with the psychiatrist as needed.

The latter approach furnishes an advantage; the primary care physician already has a working relationship with the patient which may be of considerable strength.

The techniques employed are those of brief supportive psychotherapy: encouragement, advice, exhortation, praise, suggestion, reassurance, acceptance, recognition, assurance of understanding, and help in manipulating the environment to obtain support.

The dosage is important. As with medicine it must be sufficient to be effective, but never more than the patient actually needs.

Two cases illustrate

Now I would like to offer two case vignettes as examples:

- A 26-year old mother of four children decided to have a tubal sterilization while she was in the hospital following her last delivery. The day before her scheduled surgery the patient seemed slightly depressed and apprehensive. At this point the obstetrician wisely asked for a psychiatric consultation. The patient spoke vaguely of surgical complications she feared. Gradually she revealed that she had been reared in a religiously fundamentalistic family. She was the only one of four daughters who broke with this fundamentalist tradition and severed her ties with that church. Nevertheless her mother and three sisters were urging her not to have the tubal sterilization, because they treated babies as expressions of the will of God. The obstetrician had already suggested as an alternative that the patient not have the projected tubal sterilization at this time but that she think it over and discuss it further with him at the time of her first postpartum office visit.

The psychiatrist heartily endorsed this course for two reasons. Although it may be technically easier to carry out tubal sterilizations immediately following a delivery or abortion, the

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Doctor Tourkow is chief, Division of Gynecologic Psychiatry, Department of Gynecology and Obstetrics, Wayne State University School of Medicine.

incidence of psychiatric disturbances is much higher when the procedure is carried out during these periods immediately following stress than when it is carried out during an interim period when the patient has been free of stress.

Secondly, in spite of her leading a freer life style than her fundamentalist family, the patient still carried the residuals of her childhood training in her conscience. The exhortations of her sisters and mother in this setting combined with the regression occasioned by the stress of her recent delivery resulted in her fearing punishment as if she were a bad child in seeking to have free sexual pleasure without paying the dues of having children. Only now, she displaced the fear of punishment from her parents to a parental god.

By encouraging her to wait until she had returned from this transient regression to a more adult state, the physicians permitted her to exercise her capacity for mature, independent judgment.

In addition, the obstetrician's and psychiatrist's endorsements of her personal rights and of her obligation to her children to limit her family size to one which would enable her to give them adequate care mitigated the severity of her conscience through her identification with these two benevolent parent figures.

- Another case is that of a 35-year old woman with two children. In her attempt to have her third child, which she and her husband both wanted, she conceived a tubal ectopic pregnancy. Following the subsequent salpingectomy she purposely conceived again. Unfortunately this pregnancy proved to be the same as the last. She developed an acute abdomen signaling a ruptured ectopic while she was being examined in the prenatal clinic. While waiting to be transported to the OR she pleaded with anybody in a white coat that they not take her womb. A sympathetic explanation by the resident and medical student that if the presumed diagnosis were correct she would be sterile made no change in her frantic attitude. At this point the psychiatrist who was in the clinic was brought into the case. With the agreement of the staff gynecologist, he assured her that the doctors all realized how much her womb meant to her. Therefore it would only be sacrificed if absolutely necessary to save her life, i.e. if a cornual implantation was encountered. With this assurance she lay back as if she had received an injection of morphine. Hysterectomy proved to be unnecessary. Three days postoperatively she confided to the medical student, who had visited her daily under the psychiatrist's supervision, that she had feared if she had no womb her husband would feel that something was missing the next time they had sexual intercourse. As a result he would want no further sexual contact with her.

Clearly the primary importance of her uterus to her was its symbolic contribution to her sense of value as a sexually desirable woman — a common finding among women of specific ethnic and social background. Although this patient could not be offered the guarantee she requested, the psychiatrist assured her she had communicated effectively with her doctors and that they respected her wishes. This countered her childlike fear of being the helpless victim of unnecessary surgical mutilation by knife-happy "student doctors."

Same techniques apply

I have purposely chosen more typical examples in which the stress was relatively brief and readily terminated. But the same techniques are useful in more intense forms of stress such as neonatal death and chronic or life threatening illness.

Every patient has the right to receive the complete care from his or her physician for which the psychiatric knowledge and skills which I have described are prerequisites.

For all physicians to acquire this knowledge as part of their medical training and to use these skills in their daily practice will represent modern medicine's response to Osler's advice, delivered over 60 years ago, that it is "much more important to know what sort of patient has a disease than what sort of disease a patient has."

The FTC Under Fire

(Editor's note: The following editorial comment is reprinted with permission from the Aug. 24 issue of the Detroit News.)

The Federal Trade Commission enjoys the dubious distinction of running without Congressional authorization for the past two years. The agency is expected to get a third "unauthorized" year when Congress resumes its work in September.

How can this be?

Influential friends of the agency's controversial chairman, Michael Pertschuck, are fighting any authorization bill bearing amendments designed to reduce the agency's enormous regulatory power and to prevent the agency from grabbing still more power that will cost the business community *and* the consumer millions.

To forestall these amendments, Mr. Pertschuck's friends for two years have managed to persuade Congress to simply "continue" FTC operations at existing funding levels.

That a federal agency would agree to such a funding freeze for three years suggests how frightened Mr. Pertschuck and his sponsors are of the amendments the House is bound to tack on any authorization bill.

The truth is that many liberals as well as conservatives are increasingly skeptical of the FTC's performance in recent years.

Congress passed a bill prohibiting federal agencies from requiring warranties. The FTC has called hearings on a proposal to require used car dealers to provide what is in effect a warranty. A bid in Congress to require all industries with voluntary standards to submit these standards to FTC hearings was defeated. But the FTC has scheduled hearings to do precisely what Congress refused to allow.

In short, the FTC's overly broad charter to police "unfair or deceptive acts or practices" has encouraged the agency to legislate for itself when the Congress is unreceptive to its proposals. And its long arm has reached into every aspect of American enterprise, pushing up the cost of doing business and, inevitably, the cost of goods and services.

One proposal to correct the problem co-sponsored by Sen. Carl Levin, D-Mich., would give Congress a legislative veto over any newly proposed FTC regulation. This is a moderate measure that deserves broad support. But it will not even get a serious hearing if Congress simply votes to continue funding without a formal authorization.

Since Senate liberals are, for the most part, hostile to the legislative veto, it is likely that the Senate will support another "continuance." So unless the House, which has broad bipartisan support for the legislative veto, can impose its will upon the Senate, Mr. Pertschuck & Co. will continue to do their arrogant best to keep costs and prices on the upswing.

If this Congress is truly committed to limiting the growth of government, as the 1978 campaign speeches seemed to indicate, it will move to authorize the FTC and then promptly vote for congressional veto power.

This would be the best way to put that segment of the federal bureaucracy on notice that henceforth its formidable power will be kept in check by the people's elected representatives.

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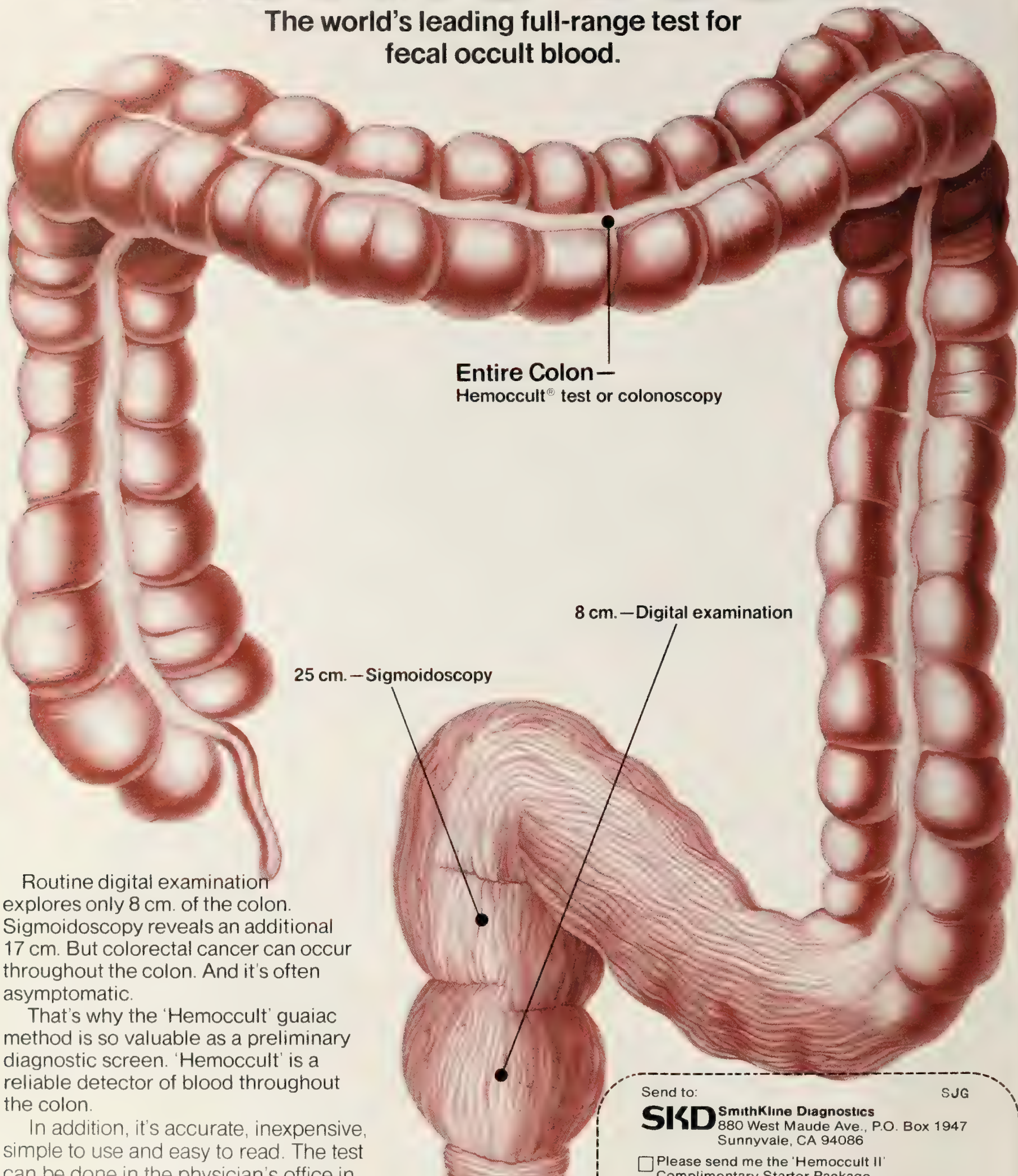

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New state mental health director to seek higher morale for entire system

By Willah Weddon
***Special to* Michigan Medicine**

Michigan's new director of the Department of Mental Health wears a clinical psychiatrist's short, white jacket while in his sixth floor office in Lansing's Cass Building. Visible under the collar, however, may be the bright red checks of a sport shirt. This tells you something about Frank M. Ochberg, MD.

Doctor Ochberg is a dedicated psychiatrist who believes members of his specialty should be more closely identified with medical doctors. He's young at 39 to head a state department but the position does not intimidate him. He's innovative in many respects but conservative in others.

He also has a sense of humor. When asked if he considered his experience in the field of terrorists' behavior an asset in taking over the post in the state's beleaguered mental health department, a grin flashed across his face.

"Well, it helped when I talked to the staff at Plymouth . . . that was the battlefield," he said. "I asked them if they ever felt they'd been held hostage." (He helped Dutch authorities negotiate with Moluccan terrorists holding hostages on a train in Holland in 1977.)

Doctor Ochberg is determined the morale of the entire network of mental health institutions be improved by cooperation between staff, patients and their parents. "The system has come under attack," he said thoughtfully. "Actually, the patients and attendants like each other . . . and parents like them too. We must stop the groups from working at loggerheads.

Doctor Ochberg

"When the Governor interviewed me, he was concerned about my interest in mental health and my track record in administration. At no time did he mention partisanship," he replied when asked if there were any political considerations in his appointment.

"The Governor assured me of his commitment to the mental health agenda and to sufficient funding."

Meets Michigan's needs

A 15-member hand-picked gubernatorial committee had spent nearly a year, and reviewed 120 applications, before narrowing the list to a few individuals from which it recommended the Governor select a new director. How well the job was accomplished is reflected in the way Doctor Ochberg's background and Michigan's needs appear to fit hand in hand.

A native of New York, he graduated cum laude from Harvard University in 1961 with a major in history and literature of England. He obtained his medical degree from Johns Hopkins University Medical School four years later, interned in the US Public Health Service Hospital in San Francisco, and finished his three year residency in psychiatry at Stanford, 1969.

While in training he joined a USPHS mental health career development program. Purpose of the program was to identify and train potential administrators in the field of mental health.

"It was a small group," he said, grinning again. "I was one of a handful to finish the program and remain in government service. It paid for my residency." This was important because he'd married Lynn Wescott while in medical school; their first child, Billie Jennifer, was born in 1964 and a second, Jesse Frank, was born in 1967. (The couple also have a ten-year-old daughter, Abigail.) Mrs. Ochberg, a non-practicing lawyer, is a talented artist who paints and does wood sculpting.

Beginning as special assistant to the deputy director of the National Institute of Mental Health (NIMH) in 1969, Doctor Ochberg rose rapidly up the ladder and served in various capacities within the Institute until he resigned as associate director of Crises Management to come to Michigan in August.

Crises management interests

His interests lie primarily in crises management, dealing with novel and catastrophic disturbances. He is a member of the International Association of Chiefs of Police, a member of

DOCTOR OCHBERG/*continued*

the National Security Council Special Coordinating Committee and was a consultant to the Federal Bureau of Investigation.

Working within a bureaucracy these past years has provided Doctor Ochberg with invaluable experience for the job in Michigan's government. "The bureaucracy is no different than other situations," he contends. "Industries, universities . . . all have the same concerns. When they grow too large, the problem is to develop trust with people you don't meet face to face."

His Washington years have also impressed on him the necessity of a department having good relations with elected officials in both political parties, appropriations committees and other key committees. He is well pleased by the reception given him by Michigan legislators.

In a short question and answer session, Doctor Ochberg expressed definite opinions:

- "I favor the broad philosophy of a community mental treatment system as compared to institutional treatment. I'm concerned about moving too quickly where we don't have good community alternatives," he qualified. "I don't favor quick discharges. I'd put the emphasis on placement."
- "I'd say the office of recipient rights (which guarantees patient's rights according to the Mental Health Code and the MDMH policy) is not yet strong enough. The office needs continuing evaluation. . . ."
- "Michigan has a good Mental Health Code."
- "The MDMH has a good continuing education program, but resources from the state universities need to be locked in with the system." He plans to meet with chairmen of the psychiatry departments in the state's universities to increase training opportunities for department doctors. "We can help the universities too, by bringing in funds for research needs."
- "Attendants have rights too, they are human beings. We need to work intensely to make their jobs performable."

When a subject catches Doctor Ochberg's interest, he begins to talk intently. The role of psychiatrists in medical care delivery today, was one of these. "It's true, psychiatrists are often low on the pecking order of physicians," he said. "It would help if psychiatrists were on call the same as other physicians.

"Psychiatrists could do much to improve relations with other specialists simply by assuming more active roles in general medical society meetings and activities," he observed, adding, "Psychiatry is at a boundary point in medicine."

Doctor Ochberg's responsibilities as MDMH director include 12 centers for developmental disabilities, 14 regional psychiatric hospitals or centers and six mental health regions. These involve adults and children, as well as attendants and staff personnel.

In addition to his other training, Doctor Ochberg spent a summer on a back ward for emotionally disturbed children at St. Elizabeth's Hospital in Washington, D.C.

"You have to develop an optimum amount of resilience to keep from getting your guts all chewed up when you see a child with handicaps. But you have to have empathy, too. . . ." his voice trailed off and it was obvious that behind his white-fringed beard, there is a man of compassion as well as competence.

OCMS survey leads to resolution on staff rights

The Oakland County Medical Society Board of Directors conducted a survey recently of its members on staff at Beaumont-Troy Hospital. The survey followed a complaint that Beaumont-Troy Hospital did not allow its medical staff either to participate in writing and revising the Bylaws or to vote by secret ballot on the acceptance of the Bylaws. Of the 68 OCMS staff members responding, 43 felt there was inadequate medical staff participation on writing, revising and voting of the medical staff Bylaws. The survey resulted in adoption of a resolution by the MSMS Annual House of Delegates which supports the medical staff of the William Beaumont Hospital and all hospital medical staffs in their right to be self-governing and to formulate and implement their constitution, bylaws, rules and regulations.

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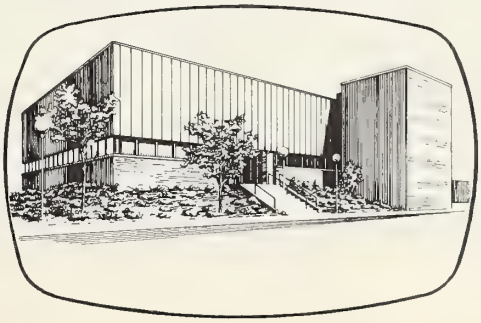

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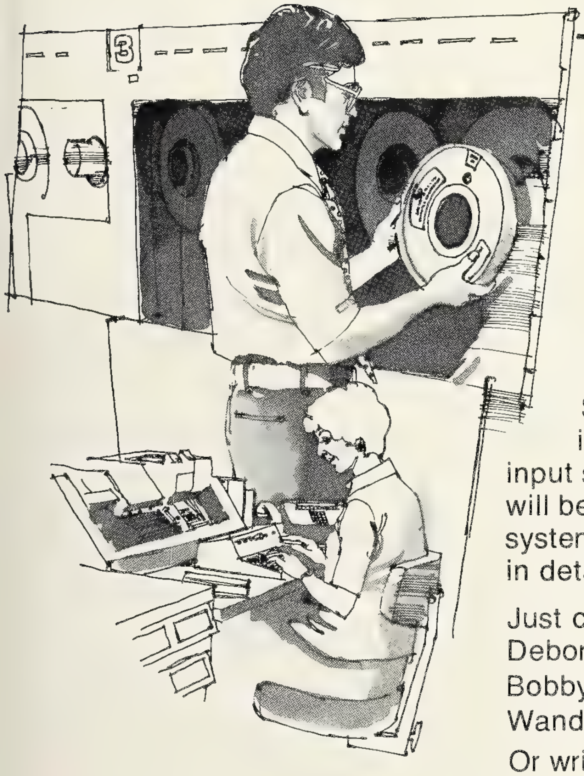

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Meet Margaret Jones, MD, dedicated physician, teacher, mother, researcher

By Charles R. Downs
Special to **Michigan Medicine**

Why do you take on so much, Doctor Margaret Z. Jones? When asked, the East Lansing neuropathologist pauses, laughs, then says seriously, "Because I have the ability and I feel committed to use it."

Later, she adds, "Opportunities and freedom to be productive and creative are precious commodities. I think it would be irresponsible for me not take advantage of them."

By that definition, it would appear that Doctor Jones is being very responsible indeed. Only nine years after coming to Michigan State University, she is a full professor of pathology striving for excellence as a teacher, researcher, and consulting pathologist.

Many colleagues think she is succeeding. Last year, when MSU presented her with a Distinguished Faculty Award, the citation noted "she not only generates creative ideas in teaching, research, and public service, but she has the capacity to take an idea and make it a reality."

("The award," she says, "was a high point because it was conferred for promoting intellectual development by a university with an excellent reputation in an area with which I have strong personal ties.")

Rural background

She admits to being a practicing workaholic, something she learned growing up and working long days on her family's thriving 600-acre peach and apple farm in southern New Jersey.

That rural background influenced her style, Doctor Jones thinks.

"It has always struck me that farm women — men too — have a much more independent life style than those in other parts of the culture," she explains. "They often have major management roles and responsibilities. Also, my family was strongly achievement-oriented."

Doctor Jones in her MSU office.

But there is more to Margaret Jones than an impulse to work hard.

"Through my teaching, I influence a lot of people," she says. "I hope I have some sort of outreach that will affect the medical scene for the better.

"I take very seriously the role-model business. Students should encounter faculty who take their work, their responsibilities, seriously.

"What we as faculty are doing should help students develop more of a sense of themselves as physicians and as problem-solvers. It's important for us to go the extra mile so that they will be encouraged to do likewise."

As a teacher, Doctor Jones has confronted the problem of teaching pathology in two medical schools (the College of Osteopathic Medicine as well as the College of Human Medicine), neither of which has a customary relationship with a teaching hospital with respect to neuropathology.

Her response has been to develop a series of neuropathology problem-solving exercises which are case studies built around actual patient histories and examples of neuropathology. She also has adapted many of the case materials for self-instruction and continuing medical education programs.

As a researcher, she has been particularly interested in the development of the nervous system. She and colleague Kathryn Lovell, MD, have been studying the nerve cells that develop after birth. They have investigated how synapses form and how chemical agents sometimes modify neural connections and make them abnormal with the result that whole areas of the nervous system may never function.

"That's very basic research," says Doctor Jones, "But I think it is very important that we try to generate new knowledge even though applications may not be readily apparent. We often forget, in this area of targeted and mission-oriented research, that those major advances have evolved from basic rather than applied research discoveries."

Doctor Jones also is interested in a new neurological disease, which, thanks to a referral from a veterinary colleague, she recently discovered in goats. The disease, which appears to be genetic, involves considerable de-

(continued on page 580)

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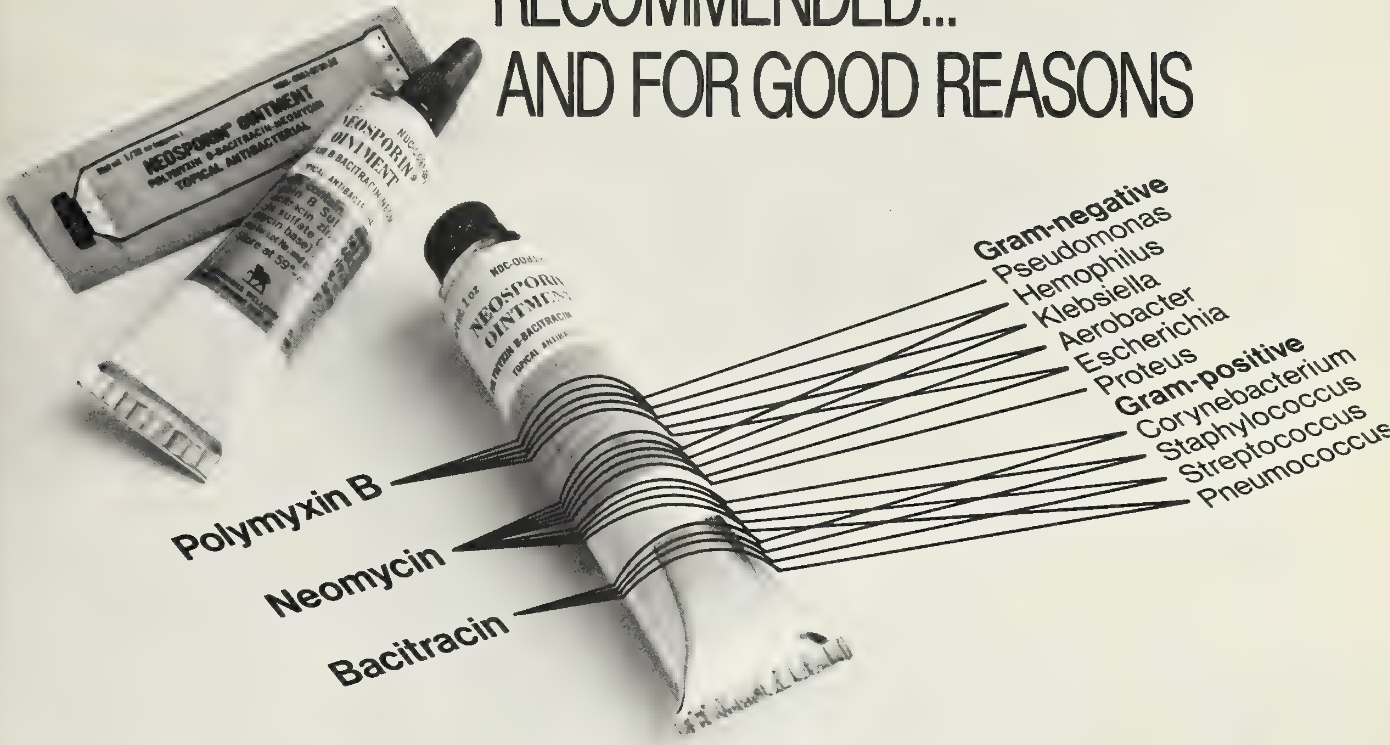
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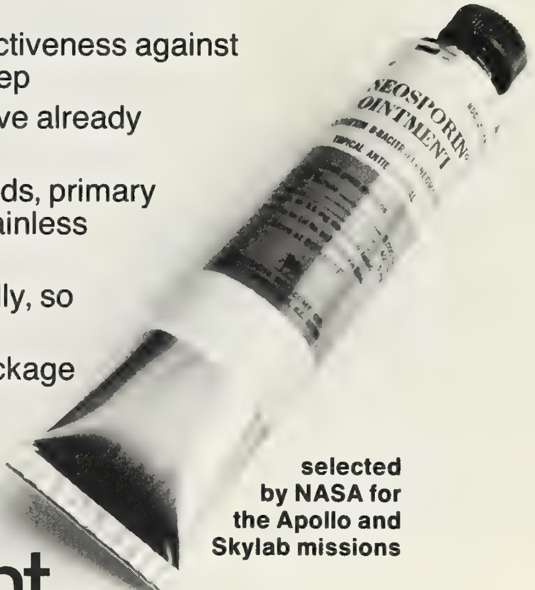
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‘Call for Action — Ask the Doctor’ is a ‘funky,’ feeling program

By W. Peter McCabe, MD
Detroit

When I was first approached about being one of the physicians answering phoned-in questions on WJR’s “Call for Action — Ask the Doctor” program, my first reaction was that this was just another tepid public relations gesture.

It would turn out to be a cosmetic means of avoiding more substantive approaches to the many problems facing medicine, I thought.

Exactly what was the Wayne County Medical Society up to in sponsoring this?

Such initial misgivings were softened somewhat when I heard there had been considerable interest in this concept expressed by the public. In addition, the program would not be broadcast; Detroit radio station WJR was limiting its involvement to publicizing the facts of the call-in format and to providing facilities for the telephoned inquiries at its studios.

And so I became a somewhat begrudging participant in the Wayne County Medical Society’s pilot programs. I must admit that some of my original skepticism was dispelled upon entering the facilities WJR had provided.

“Call for Action” volunteers, anticipating that doctor participants would be coming downtown after a full workday, had organized a buffet table worthy of the London Chop House. Their cuisine was matched by their solicitude. Coats were taken, tempers were assuaged, fevered brows were figuratively mopped, and on to the business at hand: namely, answering the questions of the troubled.

Doctor McCabe manning “Call for Action” phone lines.

We share a legacy

Which is, I suddenly realized, what we’re all about. Despite a century of scientific progress, we physicians still share as much a legacy with the priest and prophet as we do with the Einsteins and Salks among us.

A surgical subspecialist myself, a master of a ridiculously small corner of medicine but hardly a jack of anything beyond that, I realized that many of my misgivings about a project such as this reflected more on my own uncertainties than they did on the intrinsic merits of a call-in radio program. If I were to survive in this setting, it would be because of the tradition of human concern which is the bedrock of our profession.

These lofty sentiments were put to the test on my very first call. A sweet, feminine voice asked why she sweat so much at night, and what could she do about it.

Age, madame?

Seventy-eight, and proud of it.

Then ensued a series of probing questions straight out of my third year medical rotation at Cornell. Except that I received answers that might have been proffered by Charles Atlas.

In desperation I was reduced to advising fewer blankets, open windows, and light night clothes. For this I trained 13 years? Amazingly enough, she was grateful for the advice.

On came the next call.

“Doctor, I’ve been getting out of breath much more easily lately.”

Ah!, I said to myself, obviously a case of congestive heart failure. But first, let’s go through the Mayo Clinic motions.

Age?

Eighty four.

Flights of stairs?

Three, but I only live on the third floor.

What portion of a city block before you get winded?

No blocks, but after a couple of miles it gets tough.

“Miles?” I asked.

(continued on page 580)

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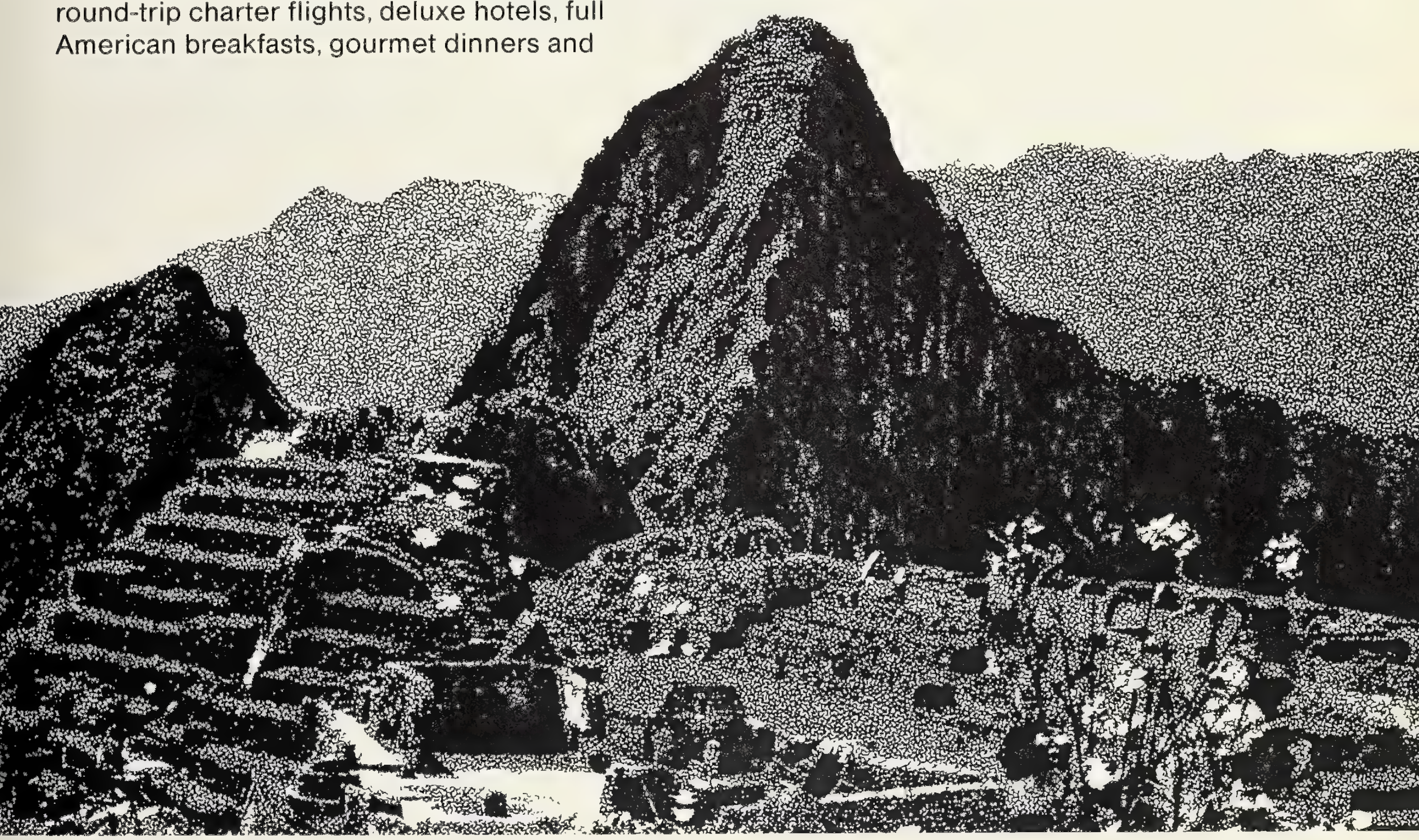

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DOCTOR JONES/*continued*

generation of the nervous system and profound neurological dysfunction at the time of birth. Since there appear to be parallels with mannosidosis in humans, Doctor Jones and her veterinary co-workers are looking into the possibility of studying the goat disease as a model of the human problem. "The extensive veterinary clinical material at MSU is a rich resource for neurological research," she notes.

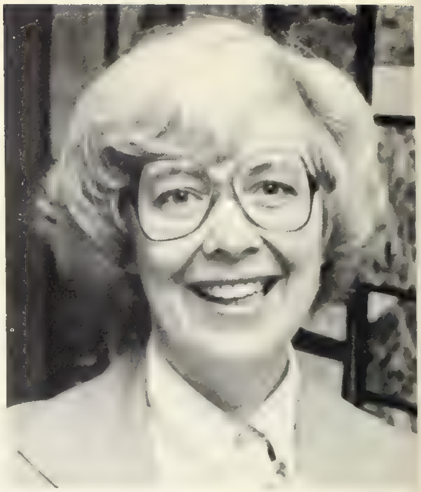
Established laboratory

And in the area of service, Doctor Jones has established and is director of the Regional Neuromuscular Diagnostic Laboratory, which studies pathological materials from patients with unusual neuromuscular diseases, many of them referred from muscular dystrophy clinics.

Along with her roles as professor, researcher, and physician, Doctor Jones is the wife of John W. Jones, MD (professor of medicine at MSU), and mother of three children — an 18-year-old son considering becoming a doctor, a 14-year-old musically-inclined daughter, and a five-year-old daughter. "Basically we have a family life steeped in tradition, but the children have been brought up to fend for themselves.

"Because of the level of commitment that Jack and I have to our work and the amount of traveling that we do," she explains, "we have a different life style than a lot of people would be willing to tolerate. We all have to make adjustments and compromises."

Doctor Jones has many goals yet to attain. One of them is becoming more involved in medical society activities, particularly in the area of biomedical ethics.



Doctor Jones

She received a National Endowment of Humanities award and attended a University of Virginia seminar this summer to study current dilemmas in health care from ethical and moral perspectives.

"Many of the major ethical problems such as prolongation of life by technological means involve neurological principles in a major way," says Doctor Jones. "Integration of these major concepts into medical student and continuing medical education efforts is currently a significant goal for me."

DOCTOR MCCABE/*continued*

"Yes, up until last year I jogged them, but I got short of breath and now I can only walk them." At this point I felt like asking *her* for advice.

Further conversation produced the fact that she volunteered at a hospital three days a week, in addition brought meals to shut-ins, and kept a healthy interest in what she perceived as the dissolution of American political life.

I was about to join her in sympathetic analysis of this latter point until I remembered the mandates of the County Medical Society. So I was left to endorsing her lifestyle, and again, to reassurance.

Shocked back to reality

Just as I was beginning to feel that Americans live to advanced but productive years, marred only by neurotic concerns over their successful longevity, I was shocked into reality by a call from a young man with ostensibly terminal kidney disease. My questions produced responses which made me feel he had been well cared for.

But still there existed a crisis of confidence whose depth could have come only from the prospect of impending death. And from such a contact comes the sense of frustration one feels in situations of such moment, the inability to alter the course of events.

Yes, one can suggest a second opinion, arranged by the Wayne County Medical Society, but isn't this what is called, in the modern vernacular, "stroking"? In a way, this question underlies the priest/scientist ambivalence that still, after centuries of scientific progress, bedevils medicine. Great progress, but still great questions.

After these three initial inquiries, which I must admit set me back on my heels, subsequent questions settled into relatively mundane concerns about such diverse subjects as acne, baldness, hernias, and hemorrhoids. I can't say that I cured, or even ameliorated, any of these concerns, but I like to think that, in my own peculiar way, I did reinforce a feeling of caring that has been passed down by generations of physicians who have preceded us. In this sense I personally have come to feel that the Wayne County Medical Society, by starting this seemingly "funky" program, has in fact responded to the best traditions in us.

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News

By Katie Brewbaker, MSMS staff

Let's go back to "the good old days," and see how it really was for several Michigan physicians who have been spotlighted in recent Michigan newspapers for their many years of medical service.

Albert H. Reisig, MD, Monroe, began practice by maintaining daily office hours and working Monday, Wednesday, and Friday nights as well. He did give himself a treat and take Saturdays off during the football season so he could attend the U-M games, but "felt a little guilty." So he'd work some Saturday nights and Sunday mornings — just in case he was needed.

And, how about his colleague **Spencer H. Wagar, MD**, Monroe, Back during The War (the big one) when the speed limit was only 35 miles per hour, Doctor Wagar delivered three babies in one hour. He delivered baby number one in Monroe, rushed to Trenton in time to bring the second baby into the world, and sped back to Monroe at 90 miles per hour to deliver the third baby.

The yearning to become a doctor and enjoy these "great" working conditions was strong.

To earn money for medical school, **Frederick J. Melges, MD**, Battle Creek, rode shotgun for railroad cars of live chickens from Minnesota to Chicago. His job was to feed this flock of chickens, clucking and feathers flying all the way, to keep them alive. In addition to receiving his pay, there was the fringe benefit of collecting the eggs laid along the way and selling them in Chicago.

Bradley M. Harris, MD, Ypsilanti, considered himself lucky during his medical studies at the U-M when he could quit hitchhiking daily from Belleville to the campus. He was "fortunate" to get a job stoking the fire at a fraternity house. What if he did have to get up every three or four hours during the night to shovel more coal on the fire? As Doctor Harris reflects, "It's still the finest education in the world. You're dealing with the human body, human mind, human being. Nowhere else are you offered the opportunity to keep people living — or help them dying." Maybe there really is something to be said for the "old days." These doctors seemed to thrive on them!

But enough about the past. . .

F. James Stewart, MD, has received the Towsley Award for his outstanding performance as a family practice resident at Midland Hospital Center. Doctor Stewart plans to begin his practice in Charlevoix upon completing his program.

Recipient of the Bruce Douglas Award is **John L. Isbister, MD**, of the Michigan Department of Public Health. The award is presented by the Michigan Thoracic Society to the physician judged by his/her peers to have made noteworthy contributions in the field of lung diseases. In making the presentation, his colleagues spoke fondly of Doctor Isbister being one of Michigan's "most colorful physicians who probably deserves more credit for the current level of tuberculosis control in Michigan than any other living physician."

MSMS Past President **Clarence I. Owen, MD**, now living in Jacksonville, Fla., has been honored by the Rotary Club for 42 years of perfect attendance. Can anyone top that!

Mary J. Kokosky, MD, has been appointed by Oakwood Hospital to serve as director of neonatal services for the care of critically ill newborns. In addition to her primary responsibility of developing an intensive care unit for newborns, Doctor Kokosky will direct training of family practice residents in the care of newborns who are critically ill.

Michigan authors

Members wishing to read articles by fellow Michigan physicians may refer to several publications. **Donald W. Hight, MD, James R. Lloyd, MD,** and **Harriet R. Bakalar, ACSW,** Detroit, have co-authored an article on "Inflicted Burns in Children: Recognition and Treatment" appearing in the Aug. 10 *JAMA*. Also featured in the Aug. 10 issue is "Exposure to Polybrominated Biphenyls: Some Effects of Personality and Cognitive Functioning" by **Robert Nixon, MD,** and **Gregory G. Brown, PhD.** The July-August issue of the *Journal of the Michigan Dental Association* carries a paper on "Medical Emergencies in Dental Practice, Part V: Miscellaneous Medical Emergencies" written by **Aaron M. Dworin, MD,** and **John P. Gobetti, DDS.** "Psychodynamic Differentiations of Homicide" is the paper by **Emanuel Tanay, MD,** published in the *Bulletin of the American Academy of Psychiatry and the Law*. The September issue of the *Journal of the American College of Emergency Physicians* carries two articles by Michigan physicians: "Esophageal Perforation Secondary to Alkaline Battery Ingestion" by **Charles L. Chabino, MD,** and **Arthur N. Feinberg, MD,** of Kalamazoo, and "Flail Chest" by **Charles Lucas, MD,** and **Judith E. Tintinalli, MD,** Detroit.

New presidents of Michigan medical specialty and health organizations are:

John N. Wolfe, MD, Detroit, Michigan Radiological Society, and **Daniel T. Anbe, MD,** Henry Ford Hospital, Division of Cardiovascular Medicine, Detroit, Michigan Heart Association.

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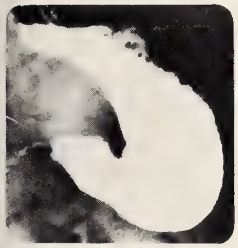
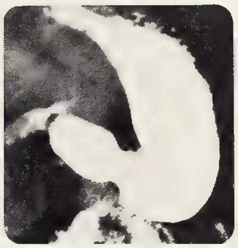
. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

---

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations; mydriasis; cycloplegia, increased ocular tension, loss of taste, headache, nervousness; drowsiness, weakness, dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs

Usual Dosage Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily. *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water) Bentyl 20 mg *Adults* 1 tablet three or four times daily Bentyl Injection *Adults* 2 ml (20 mg.) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978

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Alpena-Alcona-Presque Isle County Medical Society — President: Donald E. Miller, MD, Alpena; Secretary: Peter Aliferis, MD, Alpena General Hosp., Alpena, 49707

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Branch County Medical Society — President: N. Boonprasert, MD, Coldwater; Secretary: Wm. R. Eppler, MD, 23 N. Hanchett, Coldwater, 49036

Calhoun County Medical Society — President: J. H. Schwartz, MD, Battle Creek; Secretary: G. L. Burhans, MD, 175 College St., Battle Creek, 49017

Cass County Medical Society — President: M. S. Zaman, MD, Dowagiac; Secretary: Jashu N. Patel, MD, 515 Main St., Dowagiac, 49047

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Dickinson-Iron County Medical Society — President; W. R. Gladstone, MD, Norway; Secretary: Wm. A. Belding, MD, Dickinson County Mem. Hosp., Iron Mountain, 49801

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Gogebic County Medical Society — President: J. M. Franck, MD, Wakefield; Secretary: D. L. Davidson, MD, 200 S. Sophie, Bessemer, 49911

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Huron County Medical Society — President: C. C. Herrington, MD, Bad Axe; Secretary: R. A. Willits, MD, 193 N. Main St., Elkton, 48731

Ingham County Medical Society — President; G. D. Stilwill, MD, Lansing; Secretary: D. B. Johnson, MD, 2909 E. Grand River, Lansing, 48912

Ionia-Montcalm County Medical Society — President: Ahmad A. Younis, MD, Greenville; Secretary: L. E. Sanford, MD, 302 S. Bridge St., Belding, 48809

Isabella-Clare County Medical Society — President: Ronald A. Moss, MD, Mt. Pleasant; Secretary: Z. K. Kanjuparamban, MD, 211 S. Crapo St., Mt. Pleasant, 48858

Jackson County Medical Society — President: Robert J. Kobs, MD, Jackson; Secretary: L. E. Jennings, MD, 123 N. West Ave., Jackson, 49201

Kalamazoo County Medical Society — President: R. C. Kettunen, MD, Kalamazoo; Secretary: Fred W. Bald, MD, 252 Lovell St., Kalamazoo, 49007

Kent County Medical Society — President: R. Jack Chase, MD, Grand Rapids; Secretary: W. S. Stawski, MD, 1900 Wealthy St., SE, Grand Rapids, 49506

Lapeer County Medical Society — President: Vincente Uy, MD, Lapeer; Secretary: Leon R. Boruch, MD, 834 Liberty St., Lapeer, 48446

Lenawee County Medical Society — President: Agustin Q. Luz, MD, Adrian; Secretary: Richard D. Coak, MD, 4886 S. Adrian Hwy., Adrian, 49221

Livingston County Medical Society — President: Ismael D. Yanga, MD, Howell; Secretary: C. A. Creighton, MD, 1200 Byron Rd., Howell, 48843

Luce County Medical Society — President: E. P. Javellana, MD, Newberry; Secretary: Robert D. Gibson, MD, 207 W. John, Newberry, 49868

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Menominee County Medical Society — President: Edward J. Pienkos, MD, Menominee; Secretary: W. S. Jones, MD, 1146 Tenth Ave., Menominee, 49858

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Van Buren County Medical Society — President H. D. Fenske, MD, South Haven; Secretary: M. D. Buskirk, MD, 215 W. Kalamazoo, Paw Paw, 49079

Washtenaw County Medical Society — President: M. J. Reinhart, MD, Ann Arbor; Secretary: F. E. Patterson, MD, 3931 Penberton Lane, Ann Arbor, 48105

Wayne County Medical Society — President: C. J. France, MD, Harper Woods; Secretary: Robert W. Black, MD, 408 David Whitney Bld., Detroit, 48226

Wexford-Missaukee County Medical Society — President: S. A. Starkweather, MD, Cadillac; Secretary: R. D. Simmons, MD, 108 Locust Lane, Cadillac, 49601

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Looking for medical information? For yourself? For your patients? Call on the Michigan State Medical Society!

MSMS has a number of educational materials which Michigan physicians may use to explain a medical condition, steer an interested individual toward a health career or better explain the vagaries of medical practice.

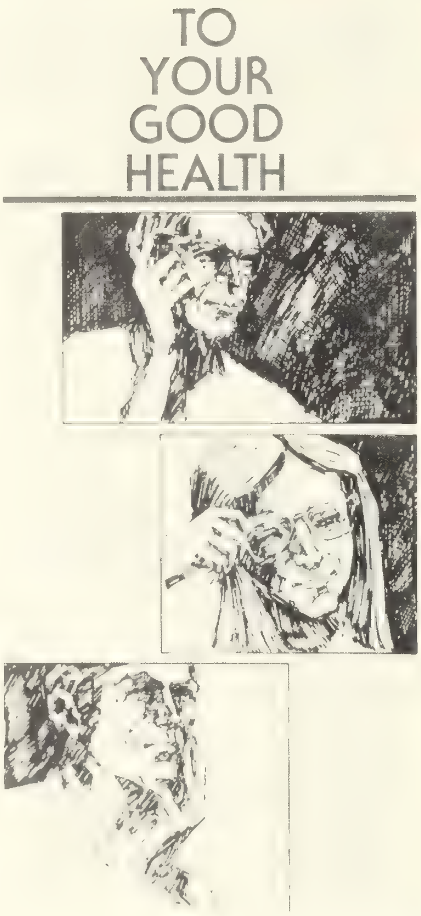
These might include the new MSMS brochure, "To Your Good Health," printed this year to help physicians talk with patients about good health care practices and the reasons for increasing medical care costs. The attractive brown, black and white brochure costs just $5 per hundred and must be ordered in multiples of 100.

Another recent MSMS offering includes the standup gold tent card which carries the message "I'm worried, too . . . about the costs of medical care. . ." and goes on to provide an opening for discussion between physicians and patients about medical care costs. This card is available free of charge.

Handsome four-color booklets on William Beaumont's Michigan history are mailed on request to interested people from MSMS headquarters.

Other pamphlets available in quantity from MSMS headquarters include guides to health careers and to materials available on health topics and health careers, published by the MSMS sister organization, the Michigan Health Council.

In addition, MSMS has ready access to AMA films, tapes, slides, books, pamphlets, brochures and other instructional and teaching guides. These are for both physician and public.



These AMA publications carry titles such as:

"You need a doctor . . . a family doctor . . . before illness strikes! Why wait?"

"Immunization"

"AMA Family Health Record"

"Your blood pressure"

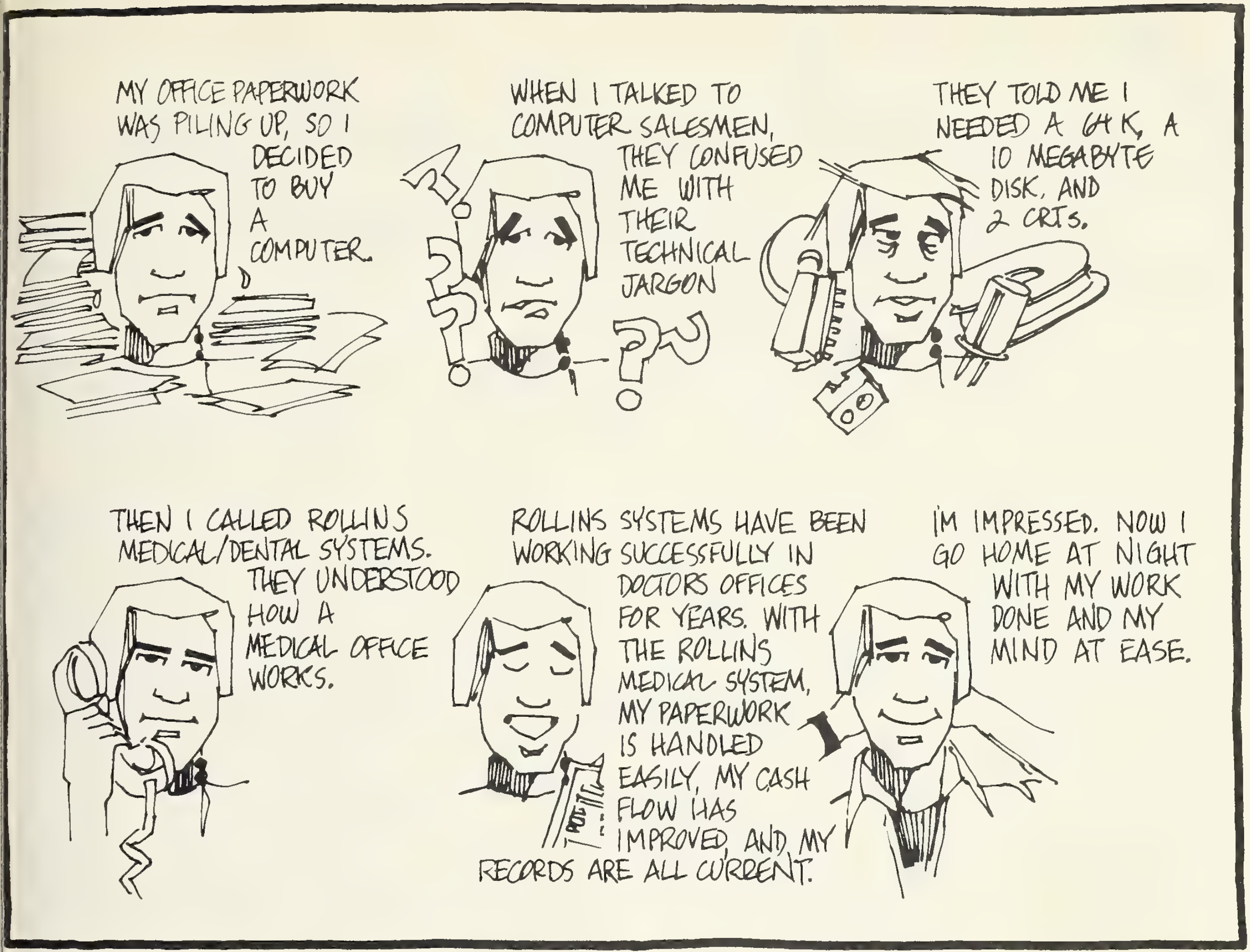
"Helping hands — the challenge of medicine"

"On being an intelligent patient"

"When to call or see your physician."

when to call
or see your
physician

Interested physicians should contact Mert Scholten at MSMS headquarters for aid in obtaining these helpful materials.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Doctor Hayes clarifies BCBSM cost containment measures

Your August 24, 1979 issue of *MEDIGRAM* (Volume 78, No. 24) contains a misstatement that should be corrected.

On the reverse side of the "Capsules" portion is the following statement relating to the Blue Cross and Blue Shield of Michigan's Cost Containment Plan:

"A certain amount will be allocated to cover a particular service for a time period and once it is paid out, no more will be available, regardless of how many more such services might be provided by physicians."

No such statement has ever been provided in writing by any member of this staff or Board of Blue Cross and Blue Shield of Michigan — nor has any statement of that kind been given verbally by any representative of Blue Cross and Blue Shield of Michigan. I suggest that it is likely a misguided misinterpretation by someone in the Michigan State Medical Society.

The Cost Containment Plan calls for us to identify total professional costs per Blue Cross-Blue Shield member — by county, region and by state. Those expenditures that exceed the average will be the target of initial investigation by the proposed regional committees, who will have the responsibility to identify the probable causes and recommend the solutions. Every attempt will be made to permit the recommended solutions to attain their objective of controlling costs. However, if the recommended solutions are not successful, alternative — and possibly more stringent — solutions may have to be recommended by either the regional committee or the Health Care Cost Committee. In no instance would such a recommendation call for a denial of a needed service to one of our subscribers.

We have faith in the integrity of the physicians in the State of Michigan. We feel that, if they are aware of the levels of cost, the causes of utilization increases and the questionable necessity of many physicians' decisions, their behavior will change. We do not feel that the behavior patterns of physicians are so intransigent that the extreme and reprehensible step of "rationing" would have to be taken.

We would appreciate whatever steps you might be able to take to correct the misunderstanding occasioned by your August 24, 1979 issue of *MEDIGRAM*.

Louis F. Hayes, MD
Vice President
Professional Affairs
Blue Cross and Blue Shield
of Michigan

". . . little creativity in promotion of healthier subscribers"

I agree with MSMS President Griffin's statement in the July, 1979 issue of *Michigan Medicine* that self-abuse is a major factor in the high cost of medical care. I, too, would be pleased to see the right to self-abuse limited, though civil rights may limit our control of these factors.

However, the health insurance carriers have shown little creativity in the promotion of healthier subscribers.

For instance, a company contracting for insurance could be assessed a rate which depended upon the proportion of employees who 1) smoke, 2) neglect seat belts, 3) drink heavily, 4) neglect exercise, 5) are obese, etc. The employer would then have an economic incentive to encourage better health habits among employees. Or the employer might pass on the excess costs to those with poor health habits, thus providing an economic reward for improvement.

Another way of influencing this high cost would be to retrain Michigan physicians 1) to readily recognize a case of high risk of self-abuse and 2) to effectively intervene through the new coercive family approaches to get this person into treatment. I believe that data already exists supporting the cost-effectiveness of this preventive care. The coercive family intervention processes are also well proven in the addictions as a "motivator for the unmotivated." So the main question remaining is "can we teach an old doctor new tricks?"

Michael R. Liepman, MD
Career Teacher in Alcoholism
and Drug Abuse
Director of Behavioral Studies
for Department of Family Practice
University Hospital
Ann Arbor

". . . enraged . . ."

I, and I am sure many other physicians are absolutely outraged by the action of the Federal Trade Commission proceeding against the Michigan State Medical Society.

I urge our society not only to resist the Federal Trade Commission with all the means at our disposal, but also to assess extra income if necessary to carry this fight as far as possible to put a muzzle on this mad dog that is running loose in Washington, known as the Federal Trade Commission.

J. L. Kihm, MD
Kalamazoo Orthopedic Surgery, PC

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Deaths

Harry J. Burkholder, MD
Alpena

Harry J. Burkholder, MD, Alpena, died July 31. He was 91. Doctor Burkholder received his MD from Johns Hopkins University in 1916. He was a member of the International College of Surgeons, the Michigan Association of Industrial Medicine and the Michigan Association of Industrial Physicians and Surgeons. Doctor Burkholder was a member of the Alpena Hospital staff and had served as chief; he also was a member of the Rogers City Hospital staff.

Gladys Kleinschmidt, MD
Muskegon

Gladys Kleinschmidt, MD, Muskegon, died August 9 at the age of 75. She received her MD in 1931 from the University of Michigan Medical School. Doctor Kleinschmidt was the retired Director of Public Health for the Mason and Manistee District. She was the author of 25 articles in public health and medical journals and is listed in *Who's Who Among American Women, Who's Who in the Midwest,* and the *Dictionary of International Biography.*

Samuel J. Levin, MD
Southfield

Samuel J. Levin, MD, Southfield, died August 29. He was 78. A clinical professor of pediatrics at Wayne State University, Doctor Levin had practiced in Detroit since 1928. He earned his MD from the University of Toronto Medical School. He was a member of the American College of Allergists, the American Academy of Pediatrics and a past president of the Michigan Allergy Society.

Ralph E. Lewis
Ann Arbor

Ralph E. Lewis, executive director of the Michigan Medical Schools Council of Deans, Ann Arbor, died August 22. He was 48. Before becoming director of the Council of Deans, Mr. Lewis worked as a project director for the Towsley Center for Continuing Medical Education at the University of Michigan and was director of professional services for the Michigan Heart Association. He was an active member of the Michigan Association for Medical Education and had served as a consultant to several MSMS committees.

Keate T. McGunegle, MD
Sandusky

Keate T. McGunegle, MD, Sandusky, died August 21. He was 66. Doctor McGunegle was the first chief of staff

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of McKenzie Memorial Hospital when the facility opened in 1967. He earned his MD from Case Western Reserve University in Cleveland.

Gabriel Tatlis, MD
Grosse Pointe Woods

Gabriel Tatlis, MD, Grosse Pointe Woods, died August 8 at the age of 74. Doctor Tatlis received his MD from Frederick Wilhelm University in Bonn. He was on the staff at Deaconess Hospital until his retirement in 1977.

Lloyd E. Verity, MD
Sarasota, FL

Lloyd E. Verity, MD, Sarasota, FL, died August 3 at the age of 82. Doctor Verity received his MD in 1920 from the University of Toronto. He was a past president of the Calhoun County Medical Society and was honored in 1968 by the National Selective Service for 25 years as a medical advisor to Local Board No. 217 in Battle Creek.

Reminder to Michigan physicians:

The U.S. Surgeon General has issued guidelines to all physicians and health professionals to help avoid the tragic complications of mixing drugs and alcohol.

The Surgeon General urged that professionals give greater attention to possible dangers of prescribing certain drugs to individuals who abuse alcohol. He noted that alcohol use in combination with other drugs accounts for approximately 20 percent of the total number of accidental and suicidal deaths per year which are drug-related.

Therefore, the Surgeon General urged all physicians and health professionals to:

1. Routinely document the history and scrutinize the pattern of alcohol consumption for individual patients to determine the possible relationship between presenting complaints and mixing drugs with alcohol;

2. Be alert to the possible interaction of prescribed, over-the-counter, or illicit drugs — singly or in combination — with alcohol;

3. Pay careful attention to the section in the package insert that deals with drug-alcohol interactions and consult the current medical literature and references for specific problems;

4. Limit as much as is practical the quantity of drugs dispensed with any one prescription and monitor the patient with regular follow-ups for unexpected reactions to the medication;

5. Consider, both in the choice of therapy and in the evaluation of the patient, the likelihood of the patient's adherence to your admonition (and that of warning label on the prescription) against using alcohol while taking medication.

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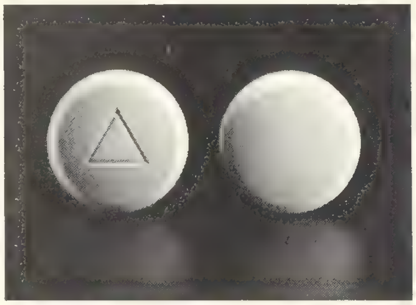
The Maker

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand–name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As y know, there is substant literature on this subje affecting many drugs, i cluding such antibiotic as tetracycline and erythromycin. The record drug recalls and court actions affirms strongl that there are differenc among pharmaceutica companies and their products. Research-intensive companies have far better records than those that do no research and may practi minimum quality assu ance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent the drug supply, including, therefore, most of t generics. Drug nomenclature is not the impo tant point; it's the comp tence of the manufacturer and the integrity the product that count.

Matters.

TH: Generic options al-
st always exist.

CT: About 55 percent
rescription drug ex-
diture is for single-
rce drugs. This
ans, of course, that for
v 45 percent of such
enditure, is a generic
scribing option avail-
e.

TH: Generic
scriptions are filled with
pensive generics, thus
ng consumers large
s of money.

CT: Market data show
t you invariably
scribe—and pharma-
s dispense—both
nd and generically
eled products from
wn and trusted
rces, in the best inter-
of patients. In most
es the patient receives
oven brand product.
ings from voluntary
nandated generic
scribing are grossly
ggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

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ADOLESCENT SERVICE DIRECTOR, to expand an existing 20 bed inpatient program to 40 beds in new facilities (open October 1, 1979) within a 383 bed community general hospital. Seek board eligible or certified psychiatrist. Established services include: 38 bed inpatient adult service, psychology services, adult partial hospitalization program, and outpatient services. Hospital deeply involved with community mental health programs in three adjacent catchment areas. Hospital has 38 bed Rehabilitation Medicine program as well as pediatrics, obstetrics, medicine and surgery. Excellent compensation package as an employee of hospital or by contract with physicians' professional corporation. Outstanding opportunity for energetic new psychiatrist out of residency. Located on river south of Detroit — 20 minutes from downtown Detroit — 30 minutes from Ann Arbor. Call collect and send resume to Bruce Nelson, Vice President for Medical Services, Wyandotte General Hospital, 2333 Biddle Avenue, Wyandotte, Michigan, 48192. 313-284-2400, ext. 2504.

OPHTHALMOLOGIST — Board certified/eligible to associate with Ophthalmologist in large Anterior Segment surgical practice. Can do Anterior Segment surgery as well as general ophthalmologic practice. Please forward Curriculum Vitae to Box 16, MSMS, 120 W. Saginaw, East Lansing, MI 48823.

WANTED — 1 or 2 family physicians to take over my office and practice so I can retire. This is a large office with 4 examining rooms and 2 consultation rooms and an adjoining dental office. Occupancy in 1980. We badly need family physicians in Jackson. Address: John W. Rice, MD, 421 McNeal Street, Jackson, Michigan 49203.

DIRECTOR OF FAMILY PRACTICE RESIDENCY PROGRAM — Full-time position for family practitioner to actively direct, administer, and expand Family Practice residency program and Chair Department in 597-bed community general teaching hospital. Primary responsibilities include supervision, teaching, selection of residents and liaison with other major teaching programs. Must be trained in Family Practice Residency Program and/or Board Certified in Family Practice; teaching experience desirable. Competitive salary and fringe benefits. Send letter and resume to: John M. Malone, MD, Chairman, Search Committee for Director of Family Practice, Mt. Carmel Mercy Hospital, 6071 W. Outer Drive, Detroit, MI 48235.

GENERAL PRACTICE OPPORTUNITIES — In a small town in South Central Michigan. Good schools, hunting, fishing and many other recreational activities. Rapid rise to full partnership for the right physician. Mostly family medicine, some surgery and obstetrics. Contact W. B. Long, MD, P. C. at telephone number 517-568-4481. 9 am to 5 pm Monday thru Friday.

AM SEEKING AN ASSOCIATE IN FAMILY PRACTICE. Will turn over practice to you in four to five years or less. Location in Western Michigan. For details contact MSMS, 120 W. Saginaw, Box 15, East Lansing, MI 48823.

MEDICAL ONCOLOGY FELLOWSHIP currently available for one or two years at the Edward W. Sparrow Hospital, Lansing, Michigan. Emphasis on clinical training with research opportunities. Prefer applicant to have completed two years of Internal Medicine training. Send Curriculum Vitae to Frances A. Breen, Jr., M.D., Director of Medical Oncology, Edward W. Sparrow Hospital, 1215 East Michigan Avenue, Lansing, Michigan 48909. A Non-Discriminatory, Affirmative Action Employer.

POSITIONS WITH STATE OF MICHIGAN — Currently taking applications for positions expected to be available in several months. Primarily interested in board certified or board eligible internists, orthopedists, and psychiatrists. Office locations at Lansing, Oak Park and Traverse City. Salary in mid 50's with approximately 23% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, M.D., Chief Medical Consultant, (517) 373-7330. In Michigan, call toll free 1-800-292-2710.

Positions wanted

ANESTHESIOLOGIST BOARD ELIGIBLE — Relocating, all types of anesthesia, including Obst., open heart — prefer group — can work with CRNAS — available immediately. Contact Subbarao Narepalem, MD, 5219 West 52nd Street, Cleveland, OH 44134.

Miscellaneous

MEDICAL SPACE FOR LEASE — 2200-4400 square feet available in Ypsilanti on Ellsworth Rd. at the corner of Hewitt. Just off the I-94 Michigan Ave. exit in busy Roundtree Village Shopping Center. Well populated area, ample parking, reasonable rent. Contact Sheldon W. Gordon in Birmingham, MI 313-647-7171.

TRAVERSE CITY MICHIGAN — Plenty of glass, magnificent modern 4 bedroom, 3 bathrooms, 2 fireplace home, living room, dining room, family room overlooking Lake Leelanau on Timberlee ski resort. Weekly or monthly, open December thru April. Call Cindy Thompson 313-882-7060 or write 16840 E. Warren, Detroit, MI 48224.

METAL PLAQUE — Honorary certificates, diplomas, photos, etc. perfectly reproduced in bright silver toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 × 12 for only $39.95. Allow four weeks. Perma-Plaque, 553 Lincoln, Grosse Pointe, Michigan, 48230, 313/884-9399.

COMPUTER FOR LEASE OR SALE — Lease this Burroughs L-8500 series computer for as low as $300.00 per month. Speed preparation of Medicaid, Medicare and Blue Shield forms. Can be completed within one minute while the patient waits. Patients' accounts updated each time on hard copy with computer storage in a memory striped ledger. No risk of loss of accounts on a faulty disc. Purchase arrangement available with price negotiable. Also available, modern, concise input forms keyed for use with the computer but very functional used alone. Contact Bruce Davenport, M.D., 2424 Spring Arbor Road, Jackson, Michigan, 49203. Phone (517) 787-6960.

LIVONIA — 7 Mile and Merriman medical building, 1350 Square Feet. Customized Suites. Immediate Occupancy. 478-2121.

MEDICAL AND DENTAL OFFICE under construction — Tremendous growth location, 16 Mile just east of Ryan Road, Sterling Heights. Available soon. Call B. Monast at 313/542-7100.

Disciplinary actions, Michigan Board of Medicine

For months of June-July-August, 1979

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

Name & Address	Date & Action Taken	Complaint
BAKKEN, Richard L, MD 200 College Battle Creek, Michigan 49017 License # 022194	6/22/79 6 Month suspension Controlled Substance License surrendered for 3 years.	Selling, prescribing giving away or administering drugs for other than lawful diagnostic or therapeutic purposes.
ANDERSON, Gordon, MD 522 E. Center St. Ithaca, Michigan 48847 License # 015060	8/1/79 Dismissed. He shall surrender his CSR & Forfeit all controlled substances to Michigan Board of Pharmacy upon request.	Negligence or failure to exercise due care. Incompetence. Fraud or deceit in obtaining a license.
BARLOW, Susan E., MD Saginaw Co-op Hospital 1020 Almira St. Saginaw, Michigan 48602 License # T55044	8/1/79 Reprimand & Probation 10 months	Unprofessional and dishonest conduct: violating rules of Act and Board. Applicant for a license is of good moral character.
BURMAN, Mathew, MD 10 W. Square Lake Rd Suite 214 Bloomfield Hills, MI 48013 License # 030145	8/10/79 Reprimand	Lifting of limited license from previous order.
FORTNER, Roscoe J., MD 137 Portage Three Rivers, Michigan 49093 License # 011786	8/1/79 Dismissed. License to be permanently surrendered & DEA & CSL to be surrendered to proper agents December 1, 1979	Failure to use reasonable care in the administration of drugs. Selling, giving away or administering drugs for other than therapeutic uses. Failure to conform to minimum standards. Unprofessional conduct.

Public Affairs Conference a must on MDs' calendars

Ernest P. Griffin, Jr., MD
MSMS President

One of the most valuable services the Medical Society provides its members is the series of special conferences sponsored throughout the year by various elements of MSMS.

Too often, I suspect, doctors tend to overlook the informational offerings close to home when casting about for new information, whether scientific, economic or political.

Yet, during the year there are a number of excellent one-, two-, or three-day conferences put on by MSMS that address a variety of specific topics. They range from the Maternal and Perinatal Conference and the Sports Medicine Conference, hoary in tradition and demonstrated value; to the intensive three-day Annual Scientific Meeting each November and its spectrum of medical topics, to the occasional practice management seminars.

Public Affairs Conference

These thoughts are generated particularly right now by the coming October 24 Public Affairs Conference sponsored by the MSMS Committee on State Legislation and Regulations. This will be only the second time this conference has been held. But, based upon evaluations by participants of the first conference last year, we can expect a first-rate presentation of governmental and political issues.

The conference will deal with the challenges of government regulations, and how physicians can counter them. Congressman Dave Stockman, from Michigan's Fourth District, is a member of the Congress' Subcommittee on Health and Environmental Affairs, and as such he has risen rapidly as a new and brilliant critic of the "Big Brother" Syndrome. He will be presented with Walter McClure, PhD, InterStudy's articulate health economist who challenges, tweaks and advises doctors on trends of the future.

Several of us who met Doctor McClure at the mid-summer meeting of The Council can attest to his capacity to level with physicians on economics issues, and to challenge us to move in new directions. Some of us who have met Congressman Stockman find here a terse, lucid, new hope in the political arena who, like McClure, will test us and tease us . . . and point out new vistas and new challenges.

The afternoon session will present three doctors who have done something about health care costs, regulations and bureaucratic meddling. Doctors W. E. Maldonado, David Siegel and Eric VanDuyne all have made their mark on the health economics of Michigan.

And I am really anxious to hear John Ylvisaker, MD, our president-elect, look 18 months ahead, based on what is said during the conference.

Rare informational opportunity

I have had the opportunity to attend the AMA's annual Conference on State Legislation, which is the precursor of the MSMS Public Affairs Conference. Both are the kinds of meetings that provide information in an organized manner that is rarely afforded us. And it's the kind of information that we all must have to be able to deal with today's and tomorrow's problems.

As President of MSMS, I encourage every component medical society to make sure it is represented at the Public Affairs Conference Oct. 24. Further, I think the larger components — those with 100 or more members — ought to send two or more physicians for every 100 members. Only through that kind of representation can the information drift back to physicians, through reports and conversations.

Amidst all the other MSMS conferences, I am glad to find this new effort in government relations.

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local rritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion ubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.,* phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buf - ers, and 1.5% benzyl alcohol as preservative.

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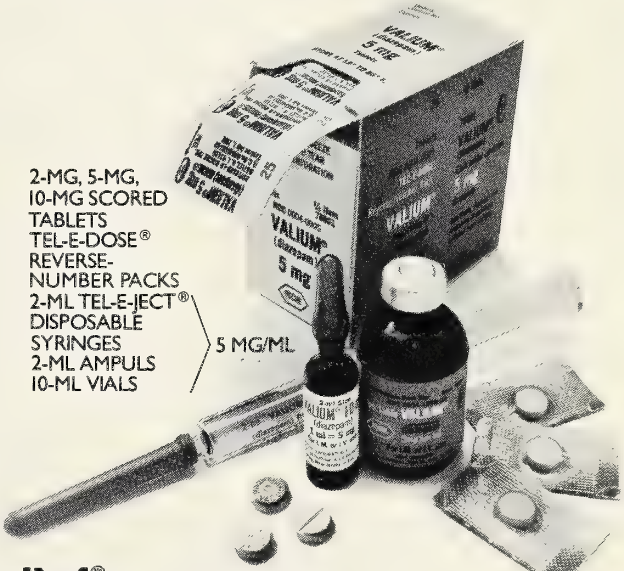

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ll as the other PSG services,
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* * *

UE CROSS BLUE SHIELD OF
CHIGAN is now tabulating
sponses to a state-wide
rvey of MDs, DOs, podiatrists
d chiropractors, and their
fice staffs. The survey is
measure attitudes on BCBSM
rticipation, reimbursement,
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proximately 1,000 surveys
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fice staffs. The survey
s conducted in September
d a report is to go to the
BSM Professional Relations
mmittee by the end of the
ar.

* * *

MS DELEGATES, ALTERNATES
D OFFICERS please take note.
e 1980 MSMS House of Dele-
tes Annual Meeting is sched-
ed for April 25-27 at the
chigan Inn in Southfield.
ture dates and sites are:
81--May 1-3, Troy Hilton;
82--April 30-May 2, Detroit
aza; and 1983--April 29-
y 1, Hyatt Regency, Dearborn.

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BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 30 OCTOBER 29, 1979

Medical marijuana bill now law in Michigan

Patients suffering from glaucoma or, in some cases, after effects of chemotherapy for cancer treatment, will be able to use marijuana under a bill signed into Michigan law by Lt. Governor James Brickley Oct. 22. The bill authorizes state-supported research into marijuana's medicinal effects as well as legalizing marijuana for therapeutic use. Only those patients certified by their physician as requiring marijuana either because their sight is threatened, or they are unable to tolerate cancer treatment, will be eligible to obtain the drug.

The MSMS House of Delegates position on the matter was forged last May in Resolution 21 stating: "That MSMS oppose all legislation that would substitute political considerations for scientific investigation and conclusions, and that when political considerations support unproven medical decisions and/or principles, they should be evaluated on an experimental basis followed by standard experimental drug protocol, or as approved by the FDA."

The new legislation carries a sunset date of 1982.

Scientific Meeting registrations mount rapidly; courses filling

Advance registrations for the forthcoming MSMS Annual Scientific Meeting reached 740 as this Medigram was going to press. This figure is well ahead of last year's registration at this time. Total course registrations have passed 2,000 as each participant signs up to attend an average of three courses. Both the Basic and Advanced Cardiac Life Support courses filled early while some other popular courses are nearly full. Advance registration is encouraged to avoid limited course selection. Advance registration forms are available in the October issue of Michigan Medicine or call Sherry Fent at MSMS (517) 337-1351.

THE MSMS JUDICAL COMMISSION is urging all component medical societies to establish ethics and mediation committees if they haven't done so already. Letters are going to all components from Judicial Commission Chairman John M. Malone, MD, in support of a 1979 MSMS House of Delegates resolution. The resolution calls for MSMS to support the strengthening of county mediation, grievance and ethics committees.

* * *

OVERFLOW CROWD HAILS MSMS PUBLIC AFFAIRS MEET...Physicians from all over Michigan heard Congressman David Stockman warn of impending federal legislation, and Walter McClure, Ph.D., lend directions to avert regulations at the second annual Public Affairs Conference held Oct. 24 in Lansing. Intense interest in IPA types of HMOs was generated as six speakers stressed that "the status quo is past; doctors can control change; competition is better than regulation." More than 100 physicians were joined by auxilians, hospital administrators and government civil servants.

U-M teaching hospital receives go-ahead to build

The University of Michigan has received final approal from the state to build its new teaching hospital complex. The Michigan Department of Public Health, in issuing the certificate of need for the hospital stipulated the cost should not exceed $210 million. The university plans to use its own funds, and thos from philanthropic donations, as well as seek up to $250 million in state funds to complete the project The new facilities will be located adjacent to the present University Hospital. The state has also issued a separate CON for renovation of the old St. Joseph Hospital, which is part of the university's plan.

Blues employees part of lifestyle/health improvement project

More than 3,000 employees of Blue Cross Blue Shield of Michigan are taking part in a pilot project designed to emphasize the value of worksite health education and promotion programs. The unique three-year program will include use of a health hazard appraisal which will measure the individual's lifesty health risks. Once these are identified the employ will receive appropriate counseling, diet advice, exercise regimens and other supportive materials aimed at helping minimize the risks while educating the employee toward healthful living. Successes of the program could lead to BCBSM efforts to establis similar programs among major subscriber groups. Th program is jointly funded by a grant from the W. K. Kellogg Foundation and BCBSM.

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Editor: Judith Marr

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PSULES

A SERIES OF COMMITTEE AP-
INTMENTS:

MS Council moved to re-acti-
te the Committee on Sports
dicine which in recent years
d functioned as a planning
mmittee for the Annual Con-
rence on the Medical Aspects
Organized Athletics. Let-
rs of invitation to serve on
e committee have been sent
a number of former members
d other physicians with par-
cular interest in sports
dicine.

e Committee on Long Range
anning has been appointed
MSMS Council Chairman Louis
Zako, MD, with the consent
the Council. Chairing the
mmittee will be MSMS Pres-
ent-elect John R. Ylvisaker,
. Other members include:
san Adelman, MD, Detroit;
rold I. Blumenstein, MD,
y City; Robert D. Burton,
, Grand Rapids; Donald K.
andall, MD, Muskegon; Larry
Fitzsimmons, MD, Lansing;
bert H. Hamburg, MD, Detroit;
lliam R. Harlan, MD, Ann
bor; Richard C. Hausler, MD,
ginaw; Raymond R. Margherio,
, Southfield; Sheldon F.
rkel, MD, Ann Arbor; Kenneth
Pitts, MD, Oakland and
talia Tanner, MD, Detroit.
visors to the committee are:
chard Leo, U of M student;
mes Malof, MD, Resident,
uthfield; Clyde Wu, MD,
arborn. Serving as Council
visors will be Ernest P.
iffin, MD, Flint and Louis
Zako, MD, Detroit.

pointed to the MSMS Pooled
nsion Trust Fund by Council
airman Zako were: Justin L.
Leight, MD, Chairman; Leland
Holly, II, MD; George A.
ling, MD; Robert E. Paxton,
and John R. Ylvisaker, MD.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 31 NOVEMBER 13, 1979

MSMS Council highlights

At its October 31 meeting, the MSMS Council:

1) Discussed a first-draft proposal for the designation of a $50,000 Financial Assistance Fund for Impaired and Disadvantaged Physicians prepared by President-Elect Ylvisaker. Doctor Ylvisaker will develop and refine the proposed plan further for later consideration by the Council.
2) Received a brief report from MSMS legal counsel on the September FTC hearing and a tentative timetable for future steps in the case. It appears that the case will be heard before an administrative law judge in mid 1980.
3) Examined a proposed set of Principles and Guidelines for Physician Involvement with Economic Aspects of the Health Care Delivery System and referred them back to the developer for further study and refinement.
4) Heard a report from David Siegel, MD, Chairman, Medicaid Liaison Committee, that the executive and legislative branches of government are at an impasse on implementing the promised Medicaid fee increase due October 1 because the state has failed to act on other appropriation measures affecting the State's fiscal crisis. MSMS has carried its argument for implementation to Gerald Miller, director, Department of Management and Budget, and alerted all parties of the disincentives to physicians should the fee increase fail to materialize.
5) Adopted the MSMS operating budget for 1980 as recommended by the Council Finance Committee which emphasizes activities in cost containment, alternative health delivery systems, Federal Trade Commission issue, membership recruitment, state and national legislation, health planning and the new Public Health Code.
6) Endorsed the Rules of Physicians Assistants proposed by the Board of Medicine with minor wording amendment and pledged MSMS support for approval of the rules by the Joint Rules Committee of the Michigan Legislature.
7) Agreed to support the Michigan Psychiatric Society's effort to seek legislation to equalize psychiatric benefits with benefits for other illnesses in terms of insurance coverage.

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MSMS members: Please complete and return to MSMS this form to join volunteer legislative network

"I WANT TO HELP IN MSMS LEGISLATIVE EFFORTS"

I'm interested in being an active member of the "MSMS Legislative Team" and hereby submit my application.

A. Name ____________________
B. Address ____________________
C. Telephone: Home __________ Office __________ Hospital __________

D. Practice Setting
   1. Private Office _____
   2. Hospital Based _____
   3. Professional Corporation _____
   4. Administration _____
   5. Public Health _____
   6. Medical School _____

E. County Society ____________________

F. Membership in Specialty Society
   1. Offices held, committee interests ____________________
   ____
   ____

G. Michigan State Medical Society
   1. Offices held, committee appointments ____________________
   ____
   ____

H. Party Affiliation
   Positions held ____________________
I. Legislative District
   1. U. S. House ____________________
   2. Michigan Senate ______________ Michigan House ______________

I'm willing to and able to do the following:

A. I'll keep in close contact through phone calls, notes and meetings on the home scene with:
   _____ My state representative. Name ____________________
   _____ My state senator. Name ____________________
   _____ My U. S. representative/senator. Name ____________________

B. I'll come to Lansing to help MSMS:
   1. Number of times per year __________ 2. Number of hours to reach Lansing ___

C. I'll attend MSMS legislative workshops and training sessions
   YES _______ NO_______ As often as I can __________

D. At this time, I will be able to participate in the program on the following date(s
   (Due to legislative scheduling, your participation would be most effective on Tuesdays, Wednesdays and/or Thursdays.) The legislature convenes mid-January to Ju
   ______________________________ (1st choice)
   ______________________________ (2nd choice)
   ______________________________ (3rd choice)

E. Legislators that I know personally:
   ____________________ ____________________
   ____________________ ____________________

egislative committee appeals for volunteer egislative network participants

ctor, your annual opportunity to come to Lansing and visit state legislators and govern- ntal executives now lies before you. The MSMS Committee on State Legislation and Reg- ations launched the Physician Legislative Network for 1980 at its November 8 meeting.

e program will begin the week of January 21 and run for 21 consecutive weeks. In past ars, this program of bringing physicians and lawmakers together, has been a cornerstone the MSMS government relations program.

rticipation in the program involves physicians and their spouses coming to Lansing for e, two or three days to meet with various legislators to talk about medicine while veloping a better understanding of the legislature and the activities of MSMS.

E. Maldonado, MD, chairman of the Legislation and Regulations Committee, strongly endorses e program and encourages all interested physicians to participate. "The physician gislative program is one of the most effective and positive efforts the medical profession involved in in bringing the concerns of quality medicine to the attention of our gislators on a personal basis," says Doctor Maldonado.

ysicians are encouraged to complete and return the volunteer form on the opposite page. il it to: Gary Anderson, MSMS, Box 950 East Lansing, MI 48823.

ch physician will be contacted for possible scheduling. Travel, lodging and meal penses are reimbursed with a $100 per diem.

ORDER FORM FOR NEW MSMS ROSTER OF MEMBERS

The 1980 MSMS Roster of Members will be published early in the year and will contain both alphabetical and county listings. Each MSMS member is entitled to one free copy but must order below to receive a copy. Additional copies for MSMS members are $10 each. Non-MSMS members, health related associations, medical schools, libraries and government departments may purchase copies at a cost of $25 each. The cost is $100 each for "for profit" corporations. Please tear off this form (your current address is on the back) and mail to MSMS, 120 W. Saginaw Street, East Lansing, MI 48823.

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CAPSULES/continued

PROPOSED STATE HEALTH PLAN II will be available for review at each Health Systems Agency (HSA) on November 15. Four public hearings are scheduled for proposed State Health Plan II as follows: December 11-Detroit; December 18-Houghton Lake; December 19-Kalamazoo and December 20-Marquette. Call the Physican/HSA Support Center for further information.

* * *

MICHIGAN'S FIRST STATE HEALTH PLAN has been acted on by the legislature. The legislature modified the plan by deleting references to state funded abortions and the dispensing of birth control services to 'mature minors'. Legislators also added a mandate to conduct an in-depth study on physician supply in Michigan. When the Statewide Health Coordinating Council adopts these changes, the 748-page State Health Plan will be the "principal guide for the development of state health programs and for the allocation of resources to health activities in the state."

Annual Conference on Maternal and Perinatal Health scheduled for Mar.

MSMS members interested in maternal health, pregnanc birth and early infant care should mark their calendars for March 5-6 when the 1980 Michigan Conference on Maternal and Perinatal Health will be held at the Hyatt Regency in Dearborn. This year's conference will feature sessions on immunology and lactation, viral infections and bacterial infections as well as the latest technological updates on monitoring, sensors and ultrasongraphy. Also scheduled are presentations on anesthesiology in both high and low risk pregnancies and permissible/prohibited drugs during pregnancy. Outstanding speakers from six states in addition to Michigan have been obtained fo the conference.

1980 MSMS dues notices in mail mid-November

1980 MSMS dues notices will be in the mail soon. Members are urged to pay promptly to receive proper credit and continuing member services. Dues are $25 for 1980 in accordance with an increase approved by the House of Delegates in May. And a reminder about MDPAC--contributions must be made by personal checks rather than on coporate accounts.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 78 No. 31, November 13, 1979

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Editor: Judith Marr

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Michigan Medicine

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Contents

November 1979, Volume 78, Number 32

Michigan Medicine

Delivering good medical care to jail inmates is the goal of an increasing number of Michigan physicians, who find the field rewarding and stimulating. MSMS has played a major role in the growth and standardization of this field, as described in this month's special section, beginning on the facing page.

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

Special Section

601 **Jail health care — the growing, challenging field is becoming recognized, standardized and accredited, with Michigan leading the field;** Austin A. Aardema, MD; Lois Storrer, RN; B. Jaye Anno

Features

606 **Lansing's Health Central has lessons on HMO development for all the state;** Charles Downs

611 **Summary of the definitive PBB study**

612 **A saga: Clearing the name Mudd:** Shelton Reece

632 **Disabilities defined for pregnant worker compensation;** Bruce Druckker, MD

636 **The MSMS Judicial Commission chafes at government regulation**

641 **Meet the MSMS staff Department of Economics and Finance**

647 **Directory of Michigan specialty society leaders**

658 **Recent vital statistics on Michigan's health care**

Departments

610 **Health Planning update**

621 **Meetings**

622 **Category I courses**

626 **MSMS/A**

631 **Business: Going Bare,** R. Timothy Hogan, CPBC

642 **Letters**

644 **News**

646 **Welcome**

652 **Views;** Norton J. Cooksey, MD; Kimball A. Miller, MD; William H. Straub, MD

662 **Deaths**

664 **Classified advertising**

666 **President's page;** Ernest P. Griffin, Jr., MD

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Jail health care evolving into rewarding, AMA-accredited opportunity

By Austin A. Aardema, MD
Muskegon

Doctor, would you consider becoming a county jail physician?

Before you give a quick "no" answer to the above question, I have some information about jail medicine to challenge you.

Since July of 1975 I have been the physician for the Muskegon County Jail. I also am a full-time family physician and chief of staff of Hackley Hospital in Muskegon.

It is my experience that the jail medical program is challenging and a change from the usual practice of medicine.

As I said I have been involved in my own jail's health care delivery for some time. Jail Nurse Barbara Aardema, RN, and I early devised and produced a medical program for the Muskegon jail which now has evolved to meet new AMA standards.

The AMA became strongly involved in 1975 when, with financial support from the Law Enforcement Assistance Administration, it undertook an enormous project — the evaluation of the medical conditions in representative jails of six states.

The purpose was to produce a set of medical standards which would insure adequate medical care for all inmates in county jails in this country.

Doctor Aardema is chairman of the Michigan Project Group for improving jail health care delivery.

This action was preceded by a 1972 study by the American Bar Association, plus many class action suits by inmates complaining about their inadequate or non-existent medical care. The courts have uniformly mandated that the denial of adequate medical care is cruel and unusual punishment and violates our United States Constitution.

The State of Michigan was chosen as a pilot state for the initial study project and a state medical society committee was formed in 1976. This committee consisted of Robert Medlar, MD, chairman; Austin A. Aardema, MD; Robert Locey, MD; John Lyons, DO, and Paul Gikas, MD.

Our committee met monthly for nearly three years and, with the excellent coordination of Richard Campau, the needed statistics regarding medical deficits in pilot jails were gathered.

The writing of our own Suggested Standards for Medical Care in Jails followed. The goals were to be practical and workable and bring community medicine into the security environment of the jail.

With our program already underway at the Muskegon County Jail, we often used the experience gained there to write our standards.

Each pilot state committee wrote suggested standards which they felt were most important. These were submitted to the AMA National Committee on the Improvement Of Medical Care In Jails. After many rewritings plus many meetings and consultations with numerous physicians, dentists and psychiatrists, a final working draft of standards was concluded by the AMA.

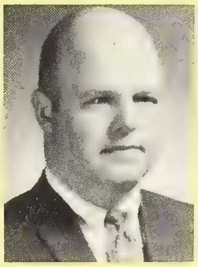
During the next year these standards were then applied to selected jails in six pilot states and the medical care program in each jail was developed to satisfy the medical standards. The results were an official accreditation by the AMA of those jails which met the standards. The standards also proved workable and practical.

Since 1977 the following jails in Michigan have been added to the jail project: Genesee, Ingham, Muskegon, Alpena, Berrien, Kalamazoo, Kent, Marquette, Saginaw, VanBuren and Grand Traverse. Jay Harness, MD, Dennis Jurzak, MD, Jerry Booth, DDS and Jeffrey Eubank of the Department of Corrections have also served the jail committee as consultants.

The AMA has a new manual to help the physician and jail to establish a medical program. MSMS and its jails project director Herb Mehler, are ready to give advice and on-site counseling on the development of new programs.

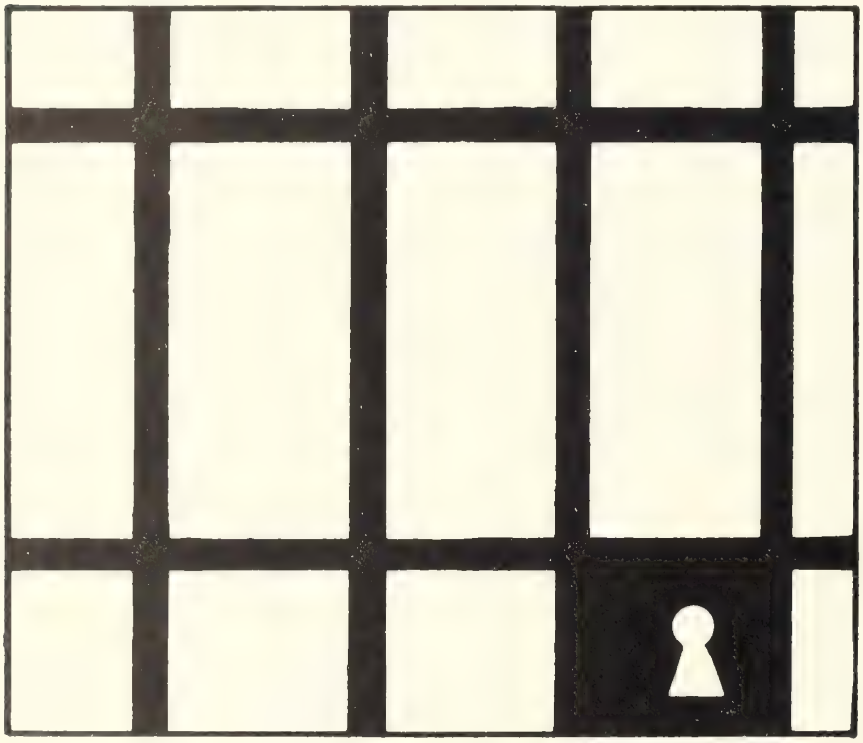
Please consider that once a program is developed it need not consume a great amount of time.

In Muskegon we have 150 jail inmates. The primary daily care is de-



Doctor Aardema

Herb Mehler, Michigan Jails Project Coordinator, presents a certificate of accreditation on behalf of the AMA, to the Washtenaw County Law Enforcement/ Corrections Center. Accepting the award is Undersheriff Curt Orsinger. Looking on are Lucy Leist, director of correctional services; and nurses Marlene Tracy and Donna Johnston.



DOCTOR AARDEMA/*continued*

livered by Michael Geoghan, RN, who is at the jail 40 hours each week.

I personally hold a weekly clinic to see the problem cases and have daily telephone consultations with Mr. Geogham. I also am available for emergency consultations by phone 24 hours per day.

Mr. Geoghan has been trained by me and functions under my standing orders to diagnose and treat the usual, common, minor problems of the inmates. He also performs routine dental and medical exams and draws blood for tests as indicated.

Mr. Geoghan coordinates the x-ray, lab, dental and medical consultants as required. The local hospital and emergency rooms serve as a backup for more serious problems which cannot be handled in jail. But in general, everything I can treat as an out-patient in family practice also can be treated in the jail environment.

The security guards have special instructions from both the nurse and me on health screening of new inmates during the booking procedure plus first aid, CPR, and the awareness of special emotional problems of inmates.

Psychiatric problems are our most frequently encountered illness. They range from situational anxiety due to being in jail, to the more serious problems of depression, psychosis, chemical dependency and suicide.

The jail physician should expect to be adequately paid for his or her work in jail. A proper contract must be arranged at the beginning specifying the duties, responsibilities and payment for the physician.

The Michigan Department of Corrections is attempting to make the AMA medical standards mandatory for every jail in our state. If they should become law, then each jail will require the services of a physician to supervise its medical program.

I hope when the call comes you will look into the needs of your particular county jail and decide that this might be just the challenge you have been awaiting.

Here's how Shiawassee Jail organizes its health care

Ms. Storrer

By Lois Storrer, RN
Owosso

When I speak to people in our Shiawassee County community about improving health care in the county jail, my listeners' first reactions are, "We're not running a country club!" The truth of the matter is, the prisoner retains his *rights* to basic needs and protection during incarceration, and this includes health care.

Why, then, should doctors, as individuals, be concerned about jail health care? Because collectively, as represented by the AMA, they are very involved!

This involvement started back in 1971 when members of the Commission on Correctional Facilities of the American Bar Association voiced their concerns to the AMA. To make a long story short, the AMA began a pilot program which now is a full-fledged effort. It is fully described in accompanying articles here.

I became involved in 1975 while working as a county nurse for the Shiawassee County Health Dept., a position I still have. The Medical Director of the health department, John Lyons, DO, assigned me to the jail as an additional duty to my public health nursing.

I had never been in a jail, much less done any nursing with an inmate population. Very slowly, my own system of providing health care evolved, mostly by trial and error.

In 1976, when the AMA representatives of the pilot program came to us with their new set of standards, I had some basic knowledge of inmate life and the problems I had encountered in trying to get medical care for the jail. It was difficult, depending upon many different physicians in the community to provide this care. Finally we met the AMA standards and received full accreditation in 1977.

Shiawassee organization

How does our jail now deliver its health care? First, there is a written contract between Robert Harroun, MD, and Sheriff Victor Moiles for the physician to be the medical director and to supervise my work.

It also states that once an inmate is admitted to the hospital, he/she is no longer Dr. Harroun's responsibility, unless returned to this facility. If an inmate has to go to the hospital emergency room, he is cared for by the E.R. physician on duty.

Health care starts from the time the inmate is booked into the jail. At this point a receiving screening is done to record information relating to current illnesses, medications, special diet, communicable diseases, etc. Behavioral observations include state of consciousness and mental status.

The health appraisal data collection is done within the first seven days of incarceration, provided the inmate will be in the jail for at least 14 days. A medical record is also started on any short-term inmate having some immediate health problems requiring treatment, medication and/or skilled observation. This health appraisal includes weight, height, tpr, B/P, VDRL, TB test, hematocrit, UA for glucose, visual inspection of skin, assessment of inmates' physical and mental status, chronic health problems, allergies and cursory examination of the teeth. This preliminary work-up is done by the nurse. At this time the inmate is asked to sign an informed consent for medical treatment.

The jail physician reviews the results of the data collection and then does a history and physical examination. Any further testing is then ordered. Doctor Harroun comes into the jail at least three hours a week to do examinations and see other inmates who have health problems. He also is available by telephone.

Rounds are made by the nurse three times a week. I go through each cell so that every inmate has the opportunity to voice complaints. We have a small dispensary where we can see inmates on a one-to-one basis. This room also is used by Ronald Luehrig, PhD, a psychologist in the Shiawassee County Community Mental Health Center. He comes into the jail on Tuesdays and on a prn basis as well. Dental care is available at the Shiawassee County Dental Clinic.

Unique field

Health care in jails is a unique field and both Doctor Harroun and I have found it interesting and challenging. This field will likely be expanded as the courts demand improved care for inmates.

If you have never given any thought to what is happening in your county jail, drop by and visit one day to see what kind of care your jail provides. It may surprise you — and then again, it may appall you.

Ms. Storrer is with the Shiawassee County Health Department and is Shiawassee County Jail nurse.

Michigan national leader in improving jail care

By B. Jaye Anno
Chicago

Correctional health care came of age in the 1970's.

In spite of the many other changes organized medicine made in health care delivery during the 50's and 60's, one segment of the population remained forgotten — the nation's prisoners. They were still "out of sight — out of mind." (This, incidentally, is the title of an award-winning film by the AMA, which addresses the problems of health care in jails, as well as current solutions.)

Organized medicine had begun to address the health care prolems of other special segments of the population in a more systematic fashion.

For example, considerable attention was focused on the unmet needs of the poor and the elderly, which resulted in national strategies to provide them with greater access to quality medical care. The special needs of children and pregnant women also began to be addressed.

Clearly, these movements as well as others underscored the notion that health care in this country is a right and not a privilege.

The inmate uprisings of the early 70's at Attica, Soledad and Rahway, brought the plight of the nation's prisoners into national prominence. There undoubtedly have been few prison riots in history not precipitated — at least in part — by the appalling conditions and inhumane treatment that existed in those institutions. In virtually every account of a riot where inmate demands were made, the list of reforms invariably included demands for improvements in diet and general living conditions, as well as improvements in the access to and adequacy of the health care provided.

The courts, too, began to focus more attention on prisoners' rights. 1972 saw "the first major federal civil rights action devoted entirely to prison medical care." U.S. District Court Judge Frank Johnson's ruling in that case — *Newman v. Alabama* — became the landmark decision which established the precedent for subsequent cases involving inmates' rights to adequate health care.

AMA survey

That same year, the AMA conducted a survey of the availability of health care services in jails, and these results helped to confirm the need for a national strategy to address the problem. Armed with these data, the AMA approached a series of private foundations and government agencies with a proposal for a program to improve health care in jails. Jails were selected as the first order of priority because as city and county facilities, they generally have fewer resources and greater needs. In 1975, the Law Enforcement Assistance Administration (LEAA) awarded the AMA a major grant to conduct a pilot program for jail health care delivery.

During the first two years of funding, primary emphasis was placed on developing model systems of health care delivery for jails of different sizes and varying resources.

The AMA's initial proposal called for the selection of six state medical societies which, in turn, selected jails in their areas to serve as pilot sites.

The Michigan State Medical Society was one of the original six subgrantees and four of the 30 pilot sites were Michigan jails. They consisted of the facilities in Lake, Oakland, Shiawassee and Washtenaw counties.

Under the guidance of an advisory committee, chaired by Robert Medlar, MD, and the able staff direction of Richard Campau and later, Herbert Mehler, MSMS saw a number of improvements take place in the health care systems of its pilot jails.

In fact, when the AMA launched its accreditation effort in August of 1977, these four Michigan facilities were among the first in the nation to receive full accreditation of their health care delivery systems.

At the end of the second year of program funding, MSMS began working with three new jails and in the third year, eight more were added. Five of these new sites also subsequently attained accreditation and significant improvements short of accreditation occurred in most of the others.

MSMS accomplishments

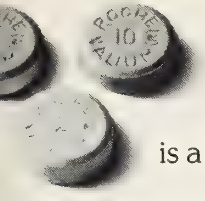
When the pilot program terminated in June of 1979, MSMS had a right to be proud of its accomplishments. The overall program had proven successful on a number of different levels as had the Michigan project. The evaluation results indicated that organized medicine could have a lasting impact on upgrading health care in jails by assisting jails to implement the AMA's standards. In other words, accreditation works.

In fact, the results demonstrated in the AMA's pilot program were of sufficient magnitude to convince LEAA that efforts to improve correctional health care should be continued. Thus, a new grant was recently awarded to the AMA to expand its program to additional jails in new areas. This year, there are 20 state medical associations participating and MSMS is once again among them.

There is still much work to be done before the right to adequate health care can be said to extend to inmates too long forgotten. But organized medicine has taken the lead in safeguarding these rights and MSMS has been a part of this effort from the beginning.

Ms. Anno is a criminologist who served as the research consultant and evaluator for the American Medical Association's pilot jail health care program. She now serves as Director of Correctional Programs for the AMA.

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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What experiences of Lansing's HMO, Health Central, can teach us all

By Charles R. Downs
Special to **Michigan Medicine**

The idealism that attended the beginning of Lansing's first operative Health Maintenance Organization (HMO) has lost its glow of fiscal naivete.

On the other hand, Health Central's backers do not find the world of financial accountability so unrelentingly dismal as they did for a few months this spring and summer.

Health Central now is under the control of the Blue Cross-Blue Shield of Michigan and seems headed for fiscal stability. It has the support of government, of labor and of thousands of Lansingites who believe it offers a better way of providing health care or a better way of paying for it, or both.

Whether Health Central fails or succeeds, medical care in the Lansing area will never be the same. Opponents as well as supporters say they have learned lessons that will affect their behavior in the future.

These lessons, though learned at one HMO's expense, are worth studying by physicians throughout Michigan for their impact on the statewide health care scene.

Two questions

Starting in December, 1977, in a remodeled post office in south Lansing, Health Central grew spectacularly in membership. In its first year, it enrolled 21,000 people when only 4,000 had been projected.

In its second year, it came close to bankruptcy, before rescue by Blue Cross-Blue Shield in August.

Discussion of that brief but mercurial history has to deal with two questions: (1) Why was Health Central so successful in its enrollment program, perhaps more so than any other HMO ever before? And, (2) why weren't the financial danger signs of that enrollment more apparent to the people in charge?

Lansing area private-practice family doctors, who apparently lost more patients to Health Central than did other specialists, tend to credit (or blame) Health Central's booming enrollment to financial attractiveness.

The HMO's prepayment is cheaper than comparable health insurance premiums and covers, importantly, the cost of routine office visits and physical examinations as well as other services normally covered by comprehensive health insurance.

Health Central supporters believe there was more to the growth than financial advantage. They maintain that many people in Lansing did not have a family doctor and that use of hospital emergency rooms for nonemergency medicine was much higher than in other Michigan cities.

The supporters also contend the comprehensive, "one-stop" health care and emphasis on preventive medicine were major factors in persuading people to join.

Whatever the motivation of subscribers, the rapid growth also can be attributed to good organization and preparation.

The background

The history goes back to 1973, when a small group of East Lansing citizens met to discuss the possibility of some sort of health clinic there. Their interest led to formation of HALE (Health Action League), a nonprofit organization instrumental in developing the state HMO legislation which became law in 1974.

HALE also applied for and received a $50,000 federal grant for an HMO feasibility study. Out of that study came Health Central and federal support in the form of a loan of $2.5 million, repayable at nine percent interest in 20 years.

Importantly, the development of Health Central was almost entirely from within the community by consumers with no vested financial interest. Importantly too, the leaders of HALE and the marketing staff of Health Central touched many important bases early in their planning. Long before Health Central opened its doors, it had the solid backing of labor and also was well known to the area's biggest employers, the state and General Motors. In other words, the market was well primed.

Still another important factor working for Health Central was the federal HMO act that requires certain employers, if approached by an HMO, to offer enrollment in the HMO as an alternative to any existing health insurance plan, and to the same degree of financial support.

Rapid growth

But even the most avid sponsors of Health Central apparently had no idea that enrollment would grow so

Lansing's HMO, Health Central

much so fast. And when they saw it they were delighted at their success. John Hennen, the executive director who was later forced to resign, assured them that with cooperation and patience from members, "we will be able to adapt in a way which will reflect the kind of health maintenance service which you expect . . ."

Nevertheless, lack of adequate staff to handle the load led Health Central to send patients to private physicians and other health services and have Health Central billed accordingly.

Loss of control of those expenditures soon had Health Central swamped by debts it could not pay, until Blue Cross-Blue Shield took control and gave it an immediate life-saving transfusion of more than $2 million with promise of more to come.

Members of Health Central's governing board fault Hennen and Controller Joseph J. Brown, who also was forced to resign, for not forewarning the Board of the problems that would ensue from overenrollment.

One of those members, Barbara Green, who was one of the prime movers of HALE, says she learned two lessons from the experience.

"One," she says, "is that a lay board has to be very zealous in not accepting information from staff uncontested.

"The other is that no institution should be allowed to grow at an uncontrolled rate."

But Ms. Green, who is an attorney and chief deputy director of the state Department of Licensing and Regulation, also notes that the state and federal HMO regulatory agencies should have forewarned the board.

"But everyone pointed to our growth as unprecedented good," says Ms. Green.

Another board member, William J. Braman, who is director of the AFL-CIO Manpower Division and president of the Lansing Labor Council, has similar thoughts.

"Board members are a volunteer group not learned in medicine, let alone in a staff model for an HMO. We need people who can ask the right questions. But in this case, even the right questions did not get good answers, despite the fact a minority on the board continued to ask them."

Strengthening experiences

Braman, who served as director of Health Central for a brief period after Hennen's departure, thinks Health Central is a better organization for the experience it had.

And Arthur Bartlett, the health center administrator who joined Health Central in March after some problems already surfaced, says that when enrollment skyrocketed, the premiums should have been increased.

"It should have been recognized," he explains, "that the start-up costs were going to be greatly increased. Eventually size can lead to a reduction in premiums, but not when you are starting up."

Bartlett also stresses the point that Blue Cross-Blue Shield has given Health Central the benefits of an established, proven managerial support system which, in the long run, may prove at least as valuable as financial support.

Thomas Bullen, appointed as acting executive director by Blue Cross-Blue Shield, points out the Health Central lesson is a reinforcement of trust in good business practices.

"People sometimes see the Blues as too conservative," he notes, "but they are still in business after 45 years because they do follow good business procedures.

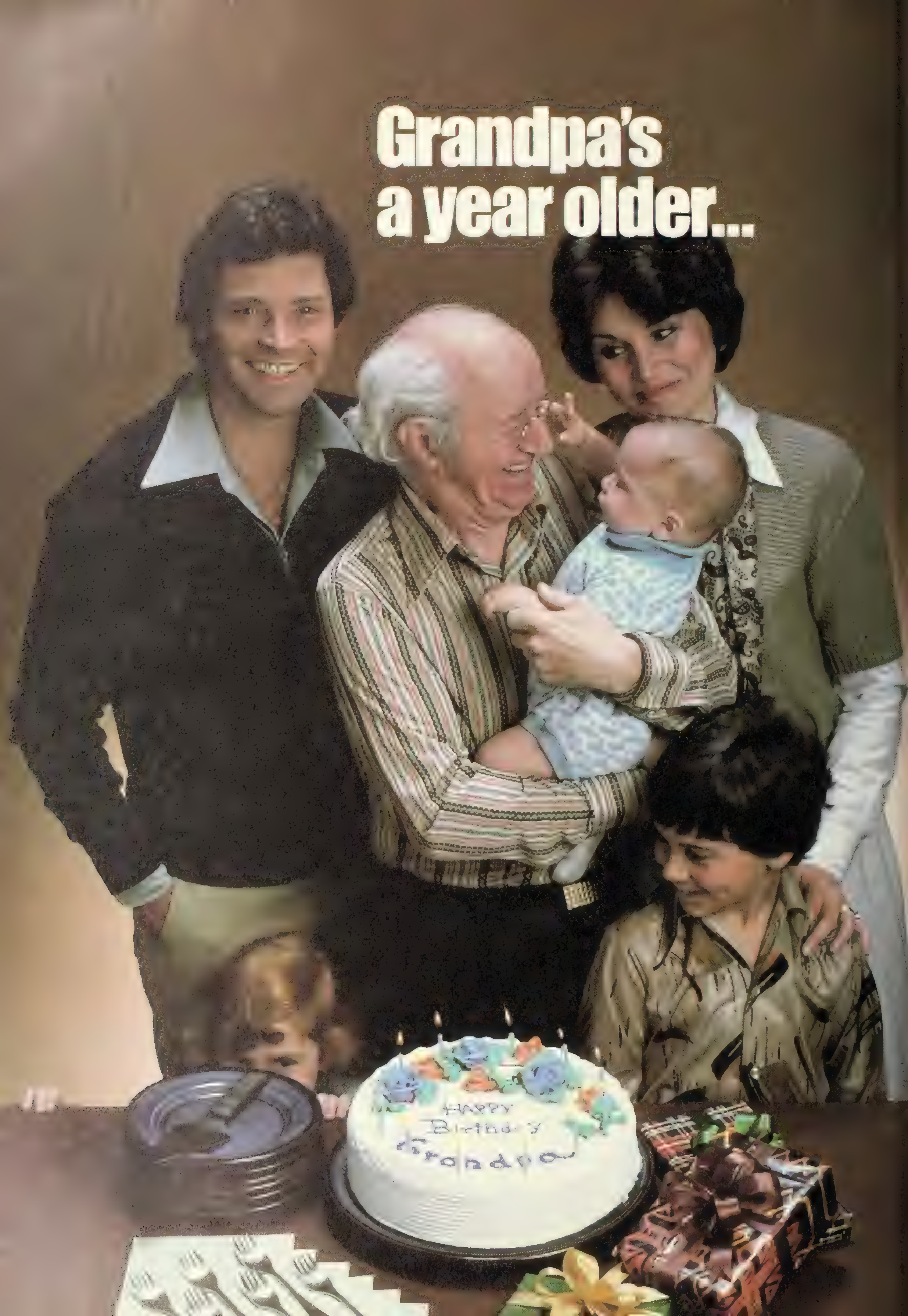
"If the Blues had been involved from the beginning, they would have either found a way to handle the sudden growth or else they would have found a way of phasing in the growth."

Blue Cross-Blue Shield is not conservative in all areas, Bullen says, explaining the reason for taking over Health Central is to see if new systems of delivering health care are workable.

"Can HMOs," he asks, "exist with good business management and without continuing government support?"

It's a good question.

(Next month: Comments on what Health Central's experiences can mean to the rest of the state.)


Grandpa's a year older...
HAPPY
Birthday
Grandpa

and at greater risk from pneumococcal pneumonia

The risks rise sharply with the years–

Although pneumococcal pneumonia can occur at any age, it is often more serious for older patients. Elderly patients are at greater risk of developing severe bacteremic infection; hospitalization is often required and recovery may be prolonged. Your elderly patients with pneumococcal pneumonia also have a significantly higher mortality rate–despite antibiotic therapy.

Vaccination with PNEUMOVAX can significantly reduce the incidence, as well as the considerable economic cost, of pneumococcal pneumonia. For your elderly patients, it offers protection against a serious and frequently debilitating illness.

PNEUMOVAX is also useful for other patients at high risk: *persons having chronic physical conditions* such as chronic heart disease of any etiology, chronic broncho-pulmonary disease, chronic renal failure, diabetes mellitus, and other chronic metabolic disorders; *persons convalescing from severe disease; persons in chronic care facilities.*

PNEUMOVAX is contraindicated in pregnant females, children under two years of age, and in the presence of hypersensitivity to any component of the vaccine. *Adverse reactions* include local erythema and soreness at the injection site; low-grade fever occurs occasionally. *PNEUMOVAX will not immunize against capsular types of pneumococci other than those contained in the vaccine.* Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions.

More than ever he may need

PNEUMOVAX®

(Pneumococcal Vaccine, Polyvalent | MSD)

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Please see following page for summary of prescribing information.

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PNEUMOVAX®
(Pneumococcal Vaccine, Polyvalent, MSD)

INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: *PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).*

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature	Pneumococcal Types													
U.S.	1	2	3	4	6	8	9	12	14	19	23	25	51	56
Danish	1	2	3	4	6A	8	9N	12F	14	19F	23F	25	7F	18C

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported.

Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. *DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.*

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

Single-Dose Prefilled Syringe
Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials
For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

J9PX12 (DC 7014803)

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For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

Health planning update

By Dennis Paradis, Director
MSMS Physician/HSA Support Center

This is the third in a regular series of health planning features planned for *Michigan Medicine* by the MSMS Physician/HSA Support Center.

State Health Plan II

A schedule for the dissemination of the second State Health Plan has been released. The plan will be available on November 15 at the office of each Health Systems Agency. A series of four public hearings are scheduled as follows:

December 17	Detroit
December 18	Houghton Lake
December 19	Kalamazoo
December 20	Marquette

Steering Committee on Health Planning expands membership

The MSMS Steering Committee on Health Planning, which was created by House of Delegates Resolution 78A-53, voted at its last meeting to expand its membership to include a physician from each HSA. The purpose of the Steering Committee is to increase physician's involvement in the health planning process.

With the appointments made at the July 7 meeting of the MSMS Council, the Steering Committee on Health Planning now includes: Kenneth J. Ray, MD, Chairman, Trenton; Billy Ben Baumann, MD, Birmingham; George Gerber, MD, Rochester; D. Bonta Hiscoe, MD, Lansing; John P. Papp, MD, Grand Rapids; Charles Seifert, MD, Battle Creek; Robert J. Toteff, MD, Saginaw; Ian Wilson, MD, Petoskey; and Norman Potter, MD, Negaunee.

Ad Hoc Committee on EMS Categorization Formed

Because of the concerns generated by the categorization of hospital emergency departments, the MSMS Steering Committee on Health Planning has formed an ad hoc committee to look into this issue.

At the urging of the ad hoc committee the Michigan Department of Public Health has formed a task force to reconsider the EMS Categorization Criteria. MSMS is represented on this task force by Brooker Masters, MD, Baldwin, and Richard Proos, MD, Kalamazoo. The task force hopes to complete its revision of the EMS Categorization Criteria before the end of the year.

State-contracted study shows little PBB residue

The following is the summary of the final report of the Michigan Department of Public Health-sponsored survey of the general population of Michigan for health effects of PBB exposure.

The final report of the survey team was released Oct. 9, 1979. The team was led by Irving J. Selikoff, MD, and Henry A. Anderson, MD, of the Environmental Sciences Laboratory of the Mt. Sinai School of Medicine of the City University of New York.

Project objectives were:

1. To determine the prevalence of detectable levels of PBB in the serum and adipose tissue in a cross-sectional population, a statistically representative sample of the general population of the State of Michigan, and

2. To investigate possible associations between detectable levels of PBB and diet, history, clinical and biochemical test results.

The analyses of the results of the clinical studies conducted between May, 1978 and September, 1978 are virtually complete.

Information obtained from the 1,738 examinations is of much interest.

While it demonstrates contamination of Michigan's food supply with PBB was widespread as the result of the accident in 1973-1974 — and that a considerable proportion of the population continues to bear some of the chemical in their tissues, five years later — for the very large majority, the amounts present are rather low, lower indeed than tissue burdens of the workers who manufactured PBB or the dairy farmers and others intimately associated with such farms.

While all sampled areas of the State had individuals with detectable PBB in their blood and tissues, the highest concentrations were found in the western portion of the State.

Additionally, males had higher concentrations than females, and children higher than adults. No racial differences were seen; however, blacks tended to have lower PBB concentrations than the whites.

A statistical association between high serum PBB and milk consumption indicated contaminated milk was the major source of PBB exposure. In addition, while meat and eggs were known to have been contaminated, our studies were unable to detect a consistent pattern between higher consumption of these foods and higher serum PBB levels.

Clinical and biochemical abnormalities were observed in the survey population and several of the findings are of public health importance (hypertension (15 percent), thyroid disease (2 percent)).

However, no significant associations were seen between the observation of these abnormalities and PBB serum level.

No unusual prevalence of symptoms was seen.

Among the over 2,000 variables in the study, only one significant pattern of symptoms emerged. That was a statistical association between variables related to increased infections (ear infections, sore throats, more frequent colds, burning on urination, slower healing of cuts) and higher serum PBB among the adults.

However, we must remember that this is only a potential hypothesis. It could be a chance effect since we have done a multitude of statistical tests, and the same relationship did not occur with the "child-infections" variables.

While the apparent increase in infection among those in the survey with higher amounts of PBB in their serum did not seem to have had serious consequences, both the Department of Public Health in Lansing and the United States Department of Health, Education and Welfare have studies underway to obtain further information on the immune function capacity of people with PBB.

In general, those examined were found to be very healthy.

This allows us to hope the lower "doses" of PBB generally suffered by people in the general population of Michigan also will present little or no trouble in the future.

This finding of lower exposure — few effects — also points up the importance of controlling contamination in the environment. In particular, it re-emphasizes the usefulness of the numerous efforts that have been made to eliminate PBB from the state's food supply in the past several years.

While some questions may exist concerning the effect of PBB on the liver or immune system, such observations may turn out to be "reactions" of organs to PBB rather than evidence of "disease" in the usual sense.

Still, scientific studies are in progress to further explore the significance of such "reactions" for the long term.

The data allows measured optimism for the years to come for the general population of Michigan. They tell us some things that might still be done, including the research needed to know how to inactivate or remove the PBB that remains in people's tissues, especially in those areas of the state where the survey showed levels to be higher.

By and large, the results of the survey are as good as we could have hoped for.

Here's the long and happy story — Doctor Mudd exonerates grandfather's name

By Shelton Reece
Special to **Michigan Medicine**

On July 24, 1979, President Carter wrote a letter to Richard D. Mudd, MD, Saginaw, expressing agreement with a full and unconditional pardon that President Andrew Johnson had granted to Samuel A. Mudd, MD, back in 1869.

The pardon set aside a military commission conviction that Doctor Samuel Mudd was a conspirator in the assassination of President Lincoln and had freed the young physician from a sentence of life in prison.

Carter's underscoring of Doctor Samuel A. Mudd's innocence did not occur by accident.

Samuel A. Mudd, MD

Doctor Mudd's crusade

It occurred because of the hard work that his grandson, MSMS member Richard D. Mudd, MD, has accomplished during more than 60 years of effort to clear his grandfather's name.

The Saginaw Doctor Mudd grew up hearing about how his grandfather — who set the broken leg of the skillfully disguised assassin, John Wilkes Booth, during early morning hours following the night of Lincoln's death — was convicted of a crime he never committed.

There was never a shred of hard evidence that the doctor conspired in the Lincoln murder. Yet he was sentenced to life in a remote prison off the Florida coast. Four years later, he was pardoned from his sentence for his heroic work during a yellow fever epidemic at the prison.

At the age of 16, Richard Mudd decided to devote as much time, effort, and money as he possibly could to clearing the family name.

That decision stayed with him through his years at Georgetown University, where he earned AB, MA, PhD (in history), and MD degrees, and through his internship and residency.

"When I took a job with General Motors in occupational medicine, I finally began to have a little money. I decided to devote some time to my self-appointed task of removing the hint of dishonor from my grandfather's name," Doctor Mudd states.

Somehow, he did find the time over the years, although he was a medical director for various divisions of General Motors from 1928 until 1966, served in the Army and Air Force Reserves from 1926 to 1961, saw five years of active duty during World War II (in which he received the Legion of Merit Award) and another year during the Korean Emergency; was on the consulting staffs of Saginaw General, Saginaw County, and St. Mary's Hospitals; a member of numerous medical, civic, church and historical groups; and became father of seven, grandfather of 35, and great-grandfather of three.

Additionally, he found time to travel extensively, make numerous speeches, collect data and to visit Lincoln historians. The active 78-year old physician estimates he has spent $90,000 over the years in travel, investigation, publishing, and secretarial services during his efforts to have his grandfather exonerated.

No full exoneration

Because a president does not have the power to over-rule a decision by a military commission, Carter's letter did not completely exonerate Doctor

(continued on page 614)

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg

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Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.

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Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
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Samuel Mudd. But it came very close.

President Carter said, in part, . . . "All legal authority vested in the President to act in this case was exercises when President Andrew Johnson granted Doctor Mudd a full and unconditional pardon on February 8, 1869.

"Nevertheless, I want to express my personal opinion that the declarations made by President Johnson in pardoning Doctor Mudd substantially discredit the validity of the military commission's judgment.

"While a pardon is considered a statement of forgiveness and not innocence, the Johnson pardon goes beyond a mere absolution of the crimes for which Doctor Mudd was convicted. The pardon states that Doctor Mudd's guilt was limited to aiding the escape of President Lincoln's assassins and did not involve any other participation or complicity in the assassination plot itself — the crime for which Doctor Mudd was actually convicted. But President Johnson went on to express his doubt concerning even Doctor Mudd's criminal guilt of aiding Lincoln's assassins in their escape.

"A careful reading of the information provided to me about this case led to my personal agreement with the findings of President Johnson . . ."

Doctor Mudd satisfied

Doctor Mudd says, "President Carter did the best he could with the legal information available to him. He certainly did more than any other president ever did.

"I feel very good about this. I believe that, in effect, it clears my grandfather. At least, it satisfies me enough that I will not carry my efforts any further.

Richard D. Mudd, MD

"I only wish there were some way that I could thank the myriad of people who have helped me with my efforts throughout the years.

"While that is impossible, I do want to express my sincere thanks to MSMS for passing Res. 47, back in 1971, urging U.S. Senators to obtain complete exoneration of Doctor Samuel A. Mudd. This was a great help in my endeavors, and I am grateful to all members."

Some historical details

Doctor Richard Mudd, who continues to practice medicine four days a week and who still plays a hard game of handball, may have decided to discontinue efforts to completely exonerate his grandfather, but because of the nature of the case there are others who may continue.

The case basically is a medical question: i.e., whether a physician has a legal and moral right to minister to all persons needing care regardless of their beliefs or crimes.

Among the many facts that Doctor Richard Mudd has gathered to support his contention that his grandfather was guiltless, and which are of great interest to others are:

- The 34-year old father of four, Dr. Samuel Mudd lived 30 miles from Washington. In those days of no telephone, radio or television, there is little likelihood that Doctor Mudd could have heard of the assassination before Booth and his companion appeared at the Mudd farm in southern Maryland approximately at 4 AM the morning after the shooting;
- Booth was heavily disguised and his companion told Doctor Mudd that the injured man had fallen from a horse;
- Doctor Mudd reported the incident to authorities soon after he learned of Lincoln's assassination;
- A military commission trial can only be held on order of the President in time of war, and contrary to the common phrase "the Civil War," an act of war was never declared in the conflict between the states;
- After the trial, a member of the commission was heard to say words to the effect that, "if it had not been for a broken leg, we never would have heard of this fellow Mudd."

There are other convincing facts that indicate Doctor Samuel Mudd did not have anything to do with Lincoln's assassination, but even if total exoneration never is achieved, Doctor Richard Mudd feels that all of his work has been worthwhile.

Few would have done so much for what they believe to be right. But then, there are few such as Richard D. Mudd, MD, Saginaw.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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At a premiere showing of TAM, are (l to r), Mrs. Anne Bielawski, Immediate Past President of the Auxiliary; Mrs. Alice Haidostian, Auxiliary Past President; Francis Rhoades, MD, Board member, Else Kolhede Memorial Foundation; Sidney Kobernick, MD, Chairman, WCMS Ad Hoc Committee for Exhibit; Carl Gagliardi, MD, Immediate Past President of WCMS; Mrs. Betty Gerisch, Chairman, 1978 Benefit Dinner Dance.

Wayne County Medical Society dedicates its TAM exhibit

The Wayne County Medical Society and its Auxiliary are donators of a major medical-scientific exhibit, the "Transparent Anatomical Manikin" (TAM) to the Detroit Science Center.

On Sept. 19, the Transparent Anatomical Manikin was unveiled and dedicated at the Detroit Science Center.

Funding for the $50,000 TAM exhibit came through extensive fund-raising efforts of the WCMS and its Auxiliary, and two grants from the Else Kolhede Memorial Foundation.

TAM is a five foot, eight inch computerized female mannequin which demonstrates internal anatomy, musculature, veins and lymphatus. Taped presentations, geared for specific audiences, identify and explain the anatomical parts as each is illuminated under the transparent skin.

Sidney Kobernick, MD, who chaired the WCMS committee in charge of the TAM project, says, "The WCMS physicians and the Auxiliary are pleased to be able to contribute this educational resource to their fellow citizens in the Detroit Community. We hope this resource will be used extensively."

TAM is housed in the Detroit Science Center's Exhibit Hall, where she lectures on her anatomical make-up and functions, using an approach based on the relative maturity of her audience. Organs, bones, muscles and nerves are very visible through the crystal-clear plastic exterior. The goal of WCMS was to further health education in the Detroit area.

Alice Haidostian, past president of the WCMS Auxiliary who dreamed four years ago of bringing TAM to Detroit, was thrilled when she saw the manikin at a preview showing. She said that "If I had been exposed to this type of exhibit as a young person, I might have developed the comprehension that was lacking in biology class."

Bradley Brewer, Detroit Science Center Director General, says, "We are extremely pleased to have a TAM here in Detroit. This is an excellent way to illustrate the normal function of various organs of the body."

Michigan hospice update

Currently in Michigan there are at least 12 programs actively pursuing hospice care.

To foster the development of these programs, and hospice care in general, a Michigan task force has been meeting since spring of 1976. State Representative David Hollister convened this citizen's task force on death and dying.

By January of 1978 the task force decided to investigate the hospice concept. A separate task force, developed to look into hospice care, holds regular meetings. Persons throughout the state are involved.

Recently, this task force has incorporated as the Michigan Hospice Organization. Its goals are to foster quality hospice programs and promote the hospice concept of providing compassionate, comprehensive, multidisciplinary care to terminally ill patients and their families within the State of Michigan. The Michigan Hospice Organization seeks to:

1) Assist in development of Hospice programs intended to provide direct care with patients and families;

2) Assist in development of interim and permanent reimbursement mechanisms which can support the development and operation of Hospices in the State of Michigan in a demonstration and permanent basis;

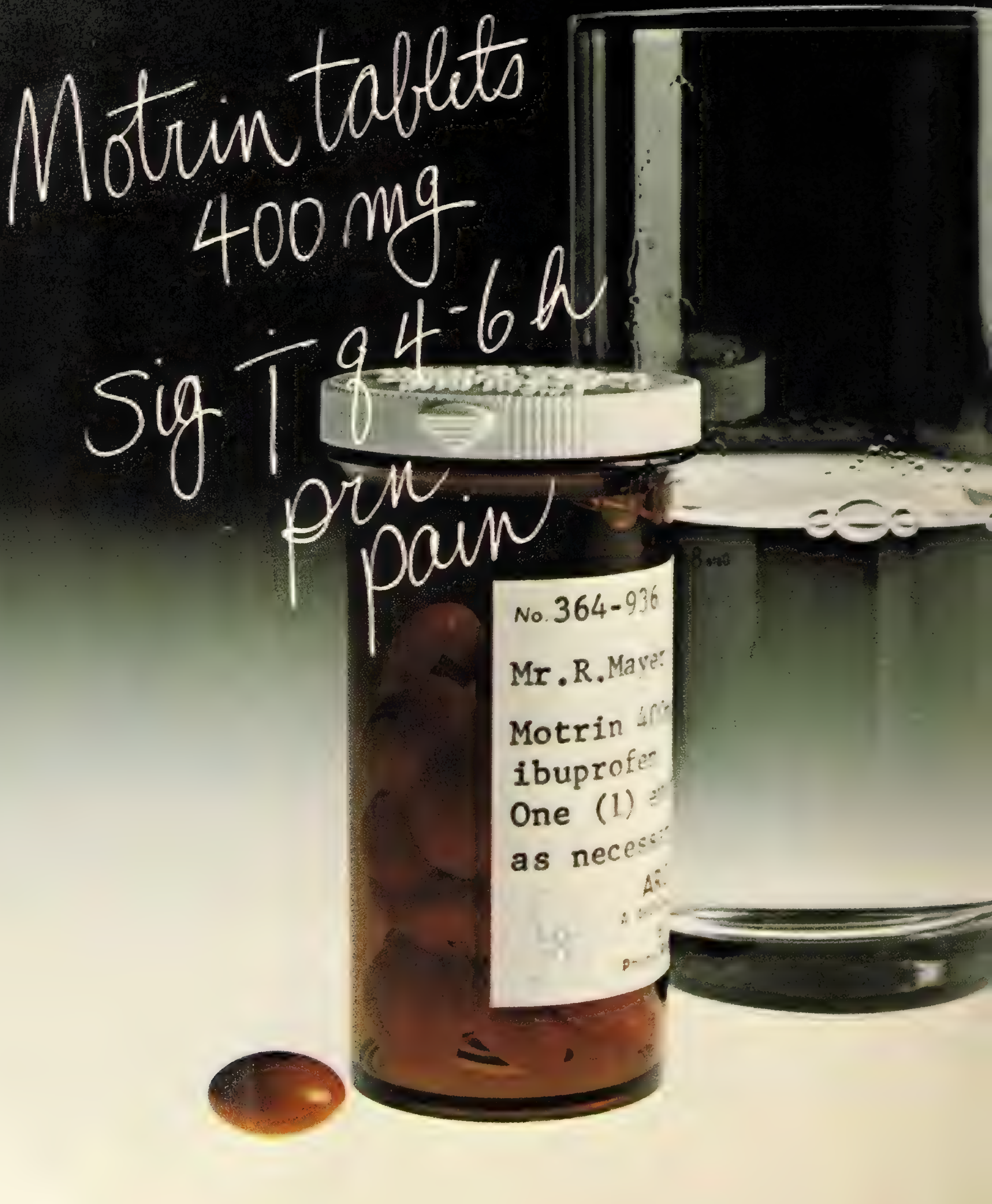
3) Foster the development of interim and permanent accreditation and license standards and of mechanisms for the monitoring and evaluation of the performance of Hospice;

4) Act as an umbrella group to provide a forum for the communication of ideas and concerns of persons with interests relating to the purposes set forth above; and

5) Develop and act as a liaison with national, regional, state, and local Hospice organizations.

The Upjohn Company announces a new indication for Motrin® (ibuprofen)

A well-tolerated, nonnarcotic prescription for pain



Motrin tablets
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Motrin now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief   1 = Partial relief   2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400 mg TABLETS

ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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August, 1979

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and 50 mg HydroDIURIL® (Hydrochlorothiazide. MSD)

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J9AR13

Meetings

MSMS, MSMS/A, AMA and medical assistants

Dec. 2-5 — AMA House of Delegates, Honolulu, Hawaii, contact: AMA headquarters 312/751-6000.

Dec. 12 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 12, 1980 — 21st AMA Conference on the Medical Aspects of Sports, San Antonio, contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn, Chicago, IL 60610.

Jan. 12-15, 1980 — AMA Winter Scientific Meeting, San Antonio, contact: Department of Scientific Assembly, AMA, 535 N. Dearborn, Chicago, IL 60610.

Feb. 2-3, 1980 — Mid-Winter Seminar, State of Michigan Branch, American Association of Medical Assistants, Weber's Inn at Ann Arbor, contact: Frances Drawe, 2171 Medford, Apt. 33, Ann Arbor, 48104.

March 9, 1980 — Board Meeting, State of Michigan Branch, American Association of Medical Assistants, MSMS headquarters, contact Caroline Rich, MSMS headquarters.

April 17-19, 1980 — Annual Convention and House of Delegates, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn at Plymouth, contact: Margaret Broadwell, 16686 East Eight Mile Rd., Detroit, 48205.

April 17, 1980 — AMA 33rd National Conference on Rural Health, Sheraton-Boston, contact: Barbara Chapman 312/751-6604 or Gary Schwartz 312/751-6431.

Other meetings

Dec. 1 — "Aspects of Countertransference in the Therapy of Borderline Patients," sponsored by Michigan Psychoanalytic Society at MPS headquarters, Southfield, contact: Ronald M. Benson, MD, Michigan Psychoanalytic Society, 16310 W. 12 Mile Rd., Suite 204, Southfield, 48076.

Dec. 12, Feb. 13, 1980, March 12, 1980 — Membership Meeting sponsored by Michigan Otolaryngological Society at Wayne County Medical Society headquarters, Detroit, contact: Dieter Wendling, MD, Macomb Ear, Nose and Throat Center, 14 Belleview, Mt. Clemens, 48043.

Jan. 12, 1980 — "Portraits of the Self: An Illustrated Case Report," sponsored by Michigan Psychoanalytic Society, at MPS headquarters, Southfield, contact: Ronald M. Benson, MD, Michigan Psychoanalytic Society, 16310 W. 12 Mile Rd., Suite 204, Southfield, 48076.

Jan. 16, 1980 — "Mediators of Immediate Hypersensitivity — New Information on Release Mechanisms," sponsored by Michigan Allergy Society at Dearborn Inn, Dearborn, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

Jan. 17-18, 1980 — Symposium on Diabetes sponsored by U-M Office of CME, at Towsley Center, Ann Arbor, contact: Towsley Center for CME, 313/764-2287.

Feb. 7, 1980 — "Object-relatedness and the Analysis of Narcissistic and Borderline Psychotic Disorders," sponsored by Michigan Psychoanalytic Society, at MPS headquarters, Southfield, contact: Ronald M. Benson, MD, Michigan Psychoanalytic Society, 16310 W. 12 Mile Rd., Suite 204, Southfield, 48076.

Feb. 9-10, March 22-23, April 26-27, May 17-18, 1980 — Sexuality Training for Professionals, at Michigan League, Ann Arbor, contact: Michael Brown, 6869 Marshall Rd., Dexter, 48130, 313/426-2334.

March 3-4, 1980 — Symposium on Diabetes, sponsored by U-M Office of CME, at Hospitality Motor Inn, Grand Rapids, contact: Towsley Center for CME, 313/764-2287.

March 19, 1980 — "Coping Styles in Bronchial Asthma Patients," sponsored by Michigan Allergy Society, at Dearborn Inn, Dearborn, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

March 27, 1980 — "Consciousness in Contemporary Psychology and Psychotherapy," sponsored by Michigan Psychoanalytic Society, at MPS headquarters, Southfield, contact: Ronald M. Benson, MD, Michigan Psychoanalytic Society, 16310 W. 12 Mile Rd., Suite 204, Southfield, 48076.

May 1-2, 1980 — Annual Meeting and Resident Surgeons Day, Michigan Chapter, American College of Surgeons, at Detroit, contact: J. H. McLaughlin, MD, 604 N. Woodward, Birmingham, 48011.

May 2, 1980 — Annual Meeting, Michigan Society of Thoracic Surgeons, at Detroit, contact: Rodman E. Tabor, MD, Michigan Society of Thoracic Surgeons, 30050 Hoover Rd., Warren, 48093.

May 7, 1980 — Executive Committee Meeting, Michigan Allergy Society, at Henry Ford Hospital, Detroit, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

May 12-13, 1980 — Symposium on Diabetes, sponsored by U-M Office of CME, at Holiday Inn, Marquette, contact: Towsley Center for CME, 313/764-2287.

June 7-8, 1980 — Spring Symposium, Michigan Otolaryngological Society, at Bay Valley Inn, Bay City, contact: Dieter Wendling, MD, Macomb Ear, Nose and Throat Center, 14 Belleview, Mt. Clemens, 48043.

June 13, 14 & 15, 1980 — Annual Meeting, Michigan Chapter, American College of Chest Physicians, at Boyne Highlands, Boyne City, contact: Susan Gibson, American Lung Association of Southeast Michigan, 28 W. Adams, Detroit, 48226, 313/961-1697.

Category I courses

Michigan Medicine ***each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.***

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Nov. 13-14-15, MSMS Annual Scientific Meeting. Location: Dearborn Hyatt Regency. **Sponsor:** MSMS. **Contact:** Sherry Fent, MSMS, 517/337-1351. **Approved for:** 18 hours of Category I Credit.

Date: Nov. 16-17, Otorhinolaryngology Update. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** Otolaryngologists and physicians dealing with head and neck diseases. **Cost:** $110. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 9¾ hours of Category I Credit.

Date: Nov. 28, Updating Core Knowledge in General Surgery. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit, 48236, 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: Dec. 8, Seminar on Diagnostic Problems in Gynecologics, Soft Tissue, and Male Genitourinary Tract Pathology. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Dr. T. A. Reyman, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, Michigan or Dr. John G. Batsakis, Department of Pathology, University of Michigan Medical Center, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 9, 16, 23 & 30, 1980, Liaison Psychiatry. Location: Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., Detroit 48235. **Approved for:** 6 hours of Category I Credit.

Date: Jan. 16, 1980, Hypertension. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236. (313/343-4000). **Approved for:** 8 hours of Category I credit.

Date: Feb. 3-8, 1980, Midwinter Family Practice Update. Location: Boyne Highlands, Harbor Springs. **Sponsor:** U-M Office of Continuing Education. **For:** All interested physicians. **Cost:** $200. **Contact: Towsley Center for CME, 313/764-2287. Approved for:** 20 hours of Category I Credit.

(continued on page 624)

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital
Oakwood Hospital, Dearborn
Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

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through Mrs. Davis at MSMS
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MICHIGAN STATE MEDICAL SOCIETY
1866

CATEGORY I/*continued*

Date: Feb. 9, 1980, New Approaches to Common Problems in Clinical Microbiology. Location: Henry Ford Hospital, Detroit. **Sponsor:** The Michigan Society of Pathologists. **For:** All interested physicians. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 9-16, 1980, Infectious Diseases Today. Location: Aboard tss Festivale in the Caribbean. **Sponsor:** Wayne State University School of Medicine, Div. of CME. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 1206 Scott Hall, Detroit, MI 48201 (313) 577-1180. **Approved for:** 36 hours of Category I Credit.

Date: Feb. 13, 20, 27 and March 5, 12 & 19, 1980, Child Development. Location: Auditorium, Mount Carmel Mercy Hospital, Detroit. **Sponsor:** Mt. Carmel Mercy Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., 48235. **Approved for:** 9 hours of Category I Credit.

Date: Feb. 18-22, 1980, Emergency Medicine. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education. **For:** Emergency physicians, Family physicians, Internists, EMT's. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 36½ hours of Category I Credit.

Date: March 19, 1980, Infectious Diseases in Obstetrics and Gynecology. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: May 2-3, 1980, Nuclear Radiology Workshop. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** $150. **Contact:** Floyd C. Pennington, Director, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109. **Approved for:** 16 hours of Category I Credit.

Date: May 21, 1980, Medical Therapy in Family Practice. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: July 25-27, 1980, EKG Interpretation and Arrhythmia Management. Location: Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** $215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112 (800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

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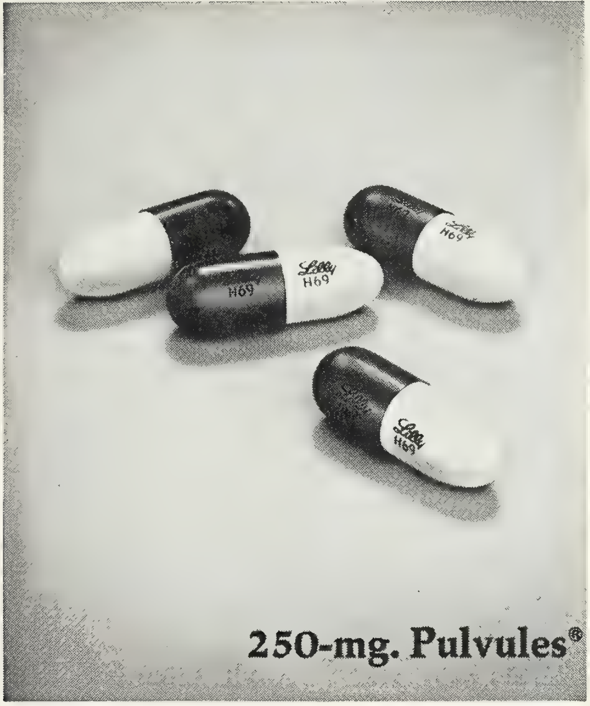
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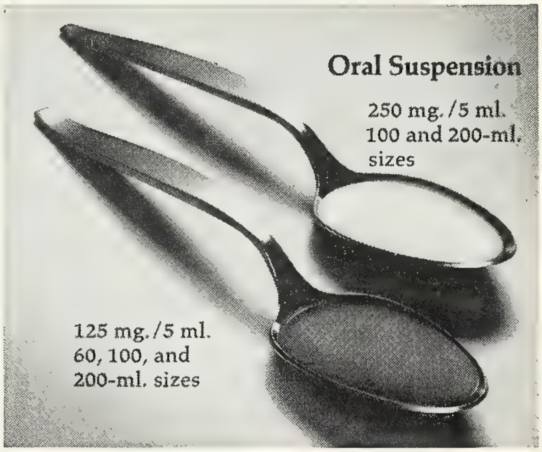
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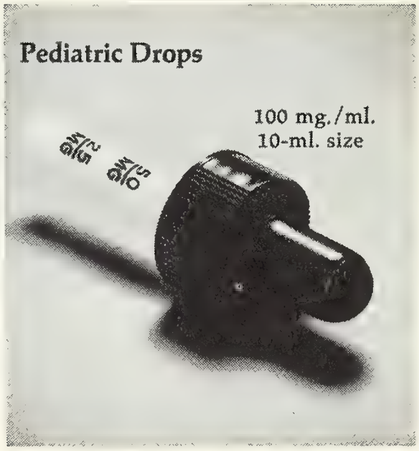
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Auxilians are winners

Mrs. Carron

By Mildred Carron
Ann Arbor

The Michigan State Medical Society Auxiliary is the winner of the state-level Award of Commendation (3rd place) in the National Awards Program of the Women's Conference of the National Safety Council. The award was presented to Mrs. Edgar (Cheri) Calvelo at the Seventh Annual Awards Breakfast of the Women's Conference Oct. 13 in Chicago. Delegates from 67 national and international women's organizations, as well as members at large, attended the breakfast and saw Cheri, the MSMS/A representative to Women for Highway Safety, receive this honor.

This is in recognition of the work of the MSMS/A to promote safe auto seat restraints for infants and children.

If your county does not promote safe auto seat restraints, we suggest that you call Cheri to begin work on this important effort. This time everyone wins. It has been proven that safe auto seats for children, when properly used, may result in an infant surviving unhurt in an auto accident when others in the care are badly injured. Don't you call this preventive medicine?

Mrs. Carron is president of the MSMS Auxiliary.

* * *

Be a show-off. Wear the MSMS/A logo, the Michigan Robin.

We have T-shirts to sell — yellow T-shirts with the bird in auxiliary (light) blue and the words, "BE A HEALTHY BIRD." The profit is for AMA-ERF. Some auxilians have outfitted their whole family. These are good cotton shirts from an established sports shop. You will enjoy them. You may order by writing or calling any county auxiliary or the MSMS/A office. We will send the shirts to you. More information will be in the MSMS/A newsletter, the "Auxilium."

* * *

Ten county presidents-elect, the state president and president-elect attended the 1979 Leadership Confluence in Chicago in October. This is one of several services provided by the AMA and the AMA Auxiliary. It is a very exhilarating experience. One meets the national leaders and has the opportunity to speak to each one personally. They answer our questions and share their experiences. They are the teachers for the workshops. We talk together about how to run a good auxiliary program, keeping in mind that we are providers, also, and must be prepared to present a favorable face for medicine. Our volunteer programs do just that. We go into our communities and prove that, "Doctors and their families care."

* * *

At the 1979 MSMS Annual Scientific Meeting at the Hyatt Regency Dearborn Nov. 13-15, the Michigan Psychiatric Society and the MSMS Auxiliary are sponsoring a session called, "Stresses Within the Physician's Family." Course director is Gail Barton, MD. The course will point to several areas of stress that we are more apt to experience than other people are, and then seek means to relieve those situations. We look upon this as an opportunity for husband and wife, (father and mother), all of us working together, to identify areas where we might work to understand and improve our communications. This is problem-solving. Everyone identifies some areas of stress, but we are not necessarily willing to recognize areas that apply to us as individuals.

This type of program is available for your community. Joyce Mason, MD, the MSMS Auxiliary representative to the MSMS Impaired Physician Committee and also a member of the Michigan Psychiatric Society Committee on The Well Being of the Physician, is preparing a program to help medical people understand and cope with some of their particular problems. Contact Mildred Carron to arrange for this program in your community.

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Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

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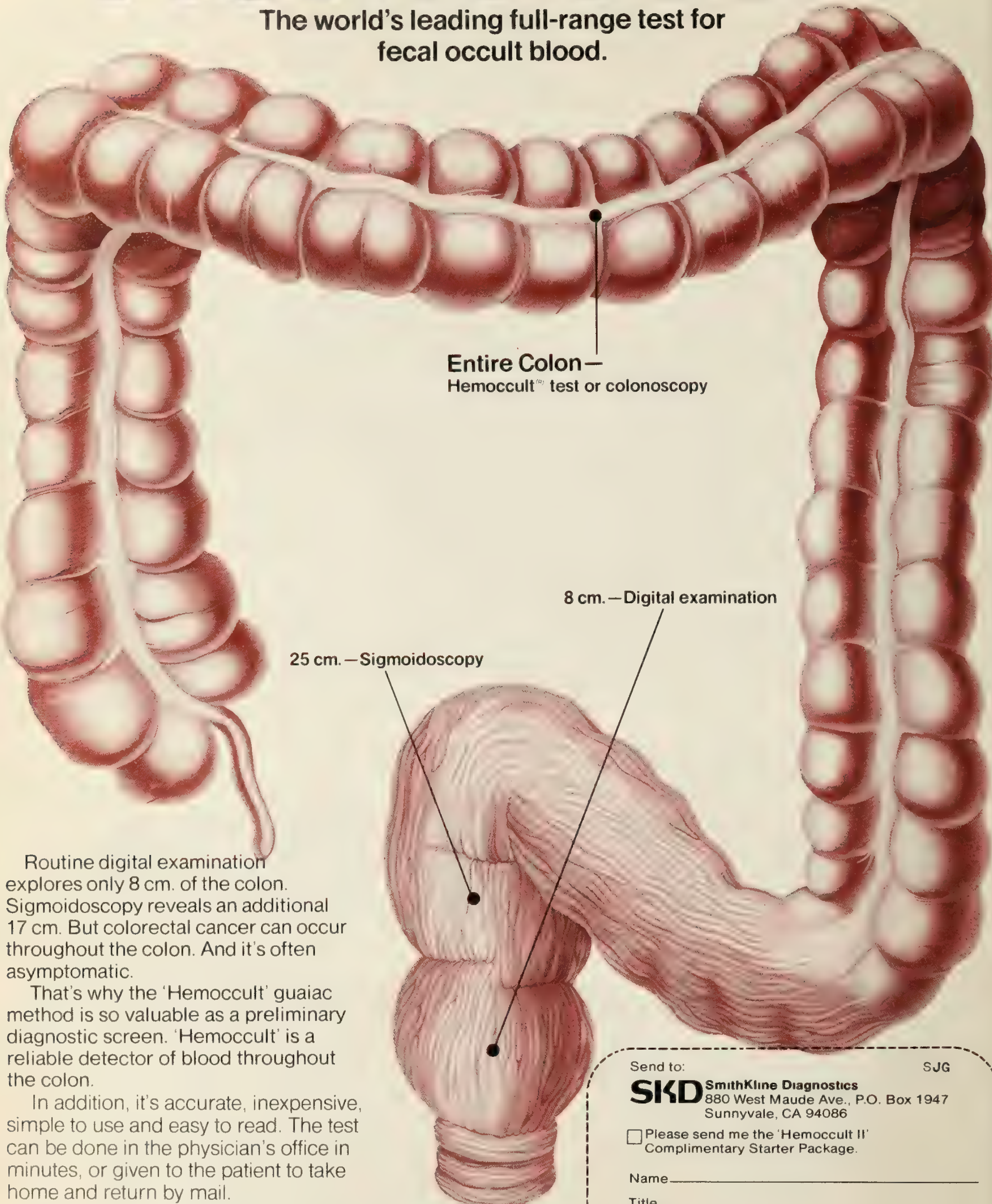

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"Going bare" losing its respectability

By R. Timothy Hogan, CPBC
Ann Arbor

"Going bare" was always a desperate tactic. Lately, the dangers of practicing without adequate professional liability insurance are becoming apparent.

Within recent months, three uninsured California physicians have been convicted of professional negligence and ordered to pay damages ranging from $175,000 to $1.9 million. One jury made the award in spite of being told that the defendant had no malpractice coverage. He has since fled the country to avoid collection efforts.

Other physicians are finding that going bare can mean trouble with their licensing boards, their hospitals, and even their fellow physicians.

Going bare was largely a byproduct of the mid-70s malpractice crisis. Few physicians prior to that would have considered doing without professional liability protection.

The calmer atmosphere prevailing today offers a good opportunity to re-examine the implications of going bare, both for those physicians who have already done so, and those still thinking about it.

What 'going bare' entails

The details of going bare can vary with the state in which the doctor lives, his or her financial condition, and the expertise of the physician's attorney. In general, the strategy requires (1) the physician discontinue professional liability insurance, and (2) the physician dispose of assets by transferring ownership to another party.

In theory, the physician who drops insurance coverage is saving money which otherwise would be spent on insurance premiums. In reality, the practitioner without professional liability insurance will have to assume the defense costs for future malpractice suits. (A recent survey reported that one out of eight physicians has been sued for malpractice in the last three years.) Depending on specialty and location, the doctor might spend more on attorney's fees than he or she would have paid in premiums.

A more serious possibility is losing a malpractice case with substantial damages being awarded the plaintiff. The "bare physician" will then be responsible for his attorney's fees *plus* the damages that would have been paid by the insurance company. One large judgment could conceivably wipe out the doctor's entire estate.

Transferring title has serious drawbacks

Some physicians try transferring title to their assets to someone else to avoid this pitfall. According to advocates of going bare, what the practitioner does not own cannot be taken away.

This maneuver has serious drawbacks and is ultimately ineffective. For one thing, transferring title means, literally, giving the assets away. Becoming a pauper after a lifetime of hard work and some degree of affluence is an eventuality which only the exceptional physician can face with equanimity.

However, the physician who retains the slightest vestige of control could someday find a court deciding that no transfer has occurred, and that "former" assets can still be attached to satisfy claims.

Secondly, the doctor becomes subject to the gift tax laws at the time of transfer, thus draining the estate by a sizable amount.

Thirdly, the doctor who successfully pauperizes himself or herself is totally dependent on the recipient of the property. The new owner may comply with the MD's wishes, but if any disruption occurs in their relationship, the doctor is without recourse.

The spouse usually is chosen to receive the assets, which raises the specter of divorce. With the divorce rate currently exceeding 40 percent, the "bare" physician's chances of losing everything through divorce are far greater than the risk of a disastrous malpractice suit.

Finally, even the physician without assets retains the prospect of future earnings. Should the physician lose a malpractice suit, the plaintiff's lawyer need only obtain a court order attaching future income until the damages have been paid.

Subpoenaing the doctor's financial records would reveal the name and address of each patient, who could be ordered by the court to send payments directly to the plaintiff. Insurance carriers could be ordered to do likewise. The physician's bank accounts could be attached, and, if he or she tried to open new ones, these could be attached every day if necessary. The plaintiff could even hire someone to sit in the office and collect any money brought in.

The bare physician who is caught in an attack on future earnings has

(continued on page 634)

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

Study identifies disabling conditions for pregnant worker compensation

By Bruce H. Druckker, MD

Seventeen obstetric and/or medical problems have been identified by a task force of the Michigan Society of Obstetricians and Gynecologists as specific reasons for disability compensation during pregnancy. The list is part of a report on pregnancy disability done for General Motors.

These 17 problems, as well as normal times permissible for disability compensation due to pregnancy, are among information in the MSOG task force report of interest to all physicians treating women of childbearing ages.

The task force established by the Society to study pregnancy-related disability reviewed available material and presented recommendations to the MSOG Council in February.

This report represents a composite opinion of the Society at the present time, based on readily-available information relating to this issue.

In addition to specific objective criteria for disability during pregnancy, other areas explored include duration of leave with compensation and leave for psycho-social factors relating to pregnancy.

Finally, the Society has offered to be a source of qualified physicians to evaluate specific claims and conditions which may arise out of various pregnancy-related, occupational disabilities.

Says the task force report:

The following obstetrical and/or medical problems should be considered as specific reasons for disability for the duration of pregnancy from the time of their onset in pregnancy, or from the time pregnancy is imposed on the pre-existing condition.

1 History of prematurity on two previous occasions with delivery of infants below 2,000 gms
2 Incompetent cervix with previous loss or cerclage
3 Uterine anomalie with previous loss
4 Cardiac disease — greater than Class II
5 Marfans Syndrome
6 Hemoglobinopathies with exception of SA (Sickle cell trait)
7 Thallessemia major — confirmed
8 Documented pulmonary hypertension
9 Herpes gestationes
10 Arterial hypertension
    1.10.1 Retinopathy >than Stage I
    1.10.2 Renal changes — abnormal creatinine clearance
11 Pre-eclampsia
12 Polyhydramnios
13 Premature labor with hospitalization
14 Third trimester intrauterine bleeding
15 Premature rupture of membranes
16 Placenta praevia
17 Multiple pregnancy from 28 weeks to term

Certain conditions have been identified as pregnancy-related and following their occurrence, should be evaluated periodically to determine the necessity of continued disability.

1 Nausea and vomiting of pregnancy — re-evaluate every 2 to 4 weeks to determine need for disability
2 Threatened abortion — re-evaluate 4 weeks after termination of bleeding
3 Anemia, severe, 8 gms or less — re-evaluate every 4 weeks for evidence of refractoriness to therapy

The task force reported it realizes there are a large number of non-disabling conditions which may be modified by, or appear during pregnancy, and these in themselves become disabling. These conditions must be evaluated on an individual basis. Examples include:

1 Seizure disorders on anticonvulsants
2 Nerve root irritation — central or peripheral
3 Cardiac arrhythmias
4 Bronchial asthma
5 Orthopaedic problems
6 Diabetes Mellitus

Environmental factors considered by the task force:

1. *Radiant energy* such as LASER, ultra violet, infra red and microwave radiant energy, is unlikely to cause significant or potential damage unless the pregnant female is actually burned by such radiant energy modes.

Bruce H. Druckker, MD, was chairman of the task force for the Michigan Society of Obstetricians and Gynecologists.

2. *Ionizing radiation* exposure must be monitored in all situations but especially during pregnancy. The recommended maximum dose for embryo/fetus during an entire gestation is 0.5 rem (rad). This is equivalent to 1.5 rem (rad) to the pregnant woman due to dose reduction by the abdominal wall in pregnant females. Film badge monitoring is mandatory for patients working in areas with potential ionizing irradiation.

3. *Heavy metals* such as *lead* and *mercury*, should be avoided. Additionally, cadmium as well as lead, may alter phagocyte oxidative metabolism and may alter the immune response of the mature female.

4. Certain organic compounds should be avoided during pregnancy. These include: polychlorinated biphenyls (PCB's), polybrominated biphenyls (PBB's), kepone, dioxin, mirex, trichlorethylene, perchlorethylene, vinyl chloride, tetrachloro-dibenzo-dioxin (TCCD), heptachlorepoxide, oxychlordane, carbon disulfide.

Although minimal information is available concerning the seventh through the 11th items, the task force noted pregnant women may be more susceptible to their effects due to the increased metabolic rate of pregnant females.

Other areas considered and offered for recommendation by the task force:

The Society feels the normal time permissible for disability with compensation due to pregnancy of an uncomplicated nature, terminating in vaginal delivery, is 6 weeks. If the patient is delivered by cesarean section in an otherwise uncomplicated pregnancy, the total period of disability with compensation, should be extended to 8 weeks.

The Society considered the number of months which would be considered feasible for leave of absence for psycho-social reasons related to pregnancy. This leave of absence would be from normal occupational activities and the employee would not sacrifice seniority, job position or other benefits. The Society feels that a period of 6 months, not including the disability for physical factors due to pregnancy per se, is an appropriate duration for this psycho-social leave of absence.

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Or write: **Physician Service Group, Inc.**
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East Lansing, MI 48823

FDA public advisory committees seeking knowledgeable members

The FDA is looking for qualified people to serve as voting members on certain public advisory committees of the Bureau of Medical Devices. The Agency is particularly interested in nominations of women and minority candidates. The term of office is 3 years.

Advisory committee members are paid $128.80 per day salary plus a per diem of $50. Travel expenses are also paid.

Nominations are being sought for members of the following committees:

- Circulatory Devices Panel
- Gastroenterology and Urology Section of the General Medical Devices Panel
- Ophthalmic; Ear, Nose and Throat; and Dental Devices Panel
- Respiratory and Nervous System Devices Panel
- Surgical and Rehabilitation Devices Panel
- Clinical Chemistry and Hematology Devices Panel
- Radiologic Section of the Obstetrics-Gynecology and Radiologic Devices Panel

In addition, FDA is seeking nominations for nonvoting consultants on the above panels as well as the following:

- General Hospital and Personal Use Section of the General Medical Devices Panel
- Obstetrics-Gynecology Section of the Obstetrics-Gyneoclogy and Radiologic Devices Panel
- Hematology Section of the Clinical Chemistry and Hematology Devices Panel
- Immunology and Microbiology Devices Panel

Nominations should be sent to Kay A. Levin, Bureau of Medical Devices (HFK-50), Food and Drug Administration, 8757 Georgia Ave., Silver Spring, Md. 20910. For further information contact Robert S. Kennedy, Bureau of Medical Devices (HFK-410) at the same address.

California OB/GYN training programs

Applications are being accepted for September, 1980 for several training opportunities for obstetricians and pediatricians at the University of California, Berkeley.

The Maternal and Child Health Program of the UC School of Public Health has programs planned in basic training in maternal and child health, adolescent health, health in the school-age child, family planning, handicapped children, comprehensive care in ambulatory pediatrics, perinatology and the doctoral program in public health.

Information is available from Helen M. Wallace, MD, professor and chairman, Department of Maternal and Child Health, University of California School of Public Health, Berkeley, CA 94720.

A consumer, says Herbert Stein, Professor of Economics, University of Virginia, is a person who is capable of choosing a President, but incapable of choosing a bicycle without the help of a government agency!

GOING BARE/*continued*

little choice except to pay. He or she could, of course, declare bankruptcy and retire from practice, assuming food and shelter could be arranged. Gifts of cash or other negotiables would be attachable.

Going bare unlikely in future

The path of the physician who goes bare is booby-trapped at many points, and some developments of the last two or three years suggest that the path itself may be closing.

At least 12 states have passed laws requiring physicians to submit proof of malpractice coverage or equivalent financial responsibility as a condition of licensure or relicensure. Certain hospitals also are demanding that staff physicians carry insurance in order to qualify for privileges.

Physicians are bringing suits which challenge the power of both states and hospitals to impose such requirements. Some cases have been won by the doctors; others by the defendants.

But an ominous sign is that no court has yet ruled that a state or hospital lacks the right to mandate insurance. Doctor victories have all been won on the basis of defects in the laws or regulations.

Another important development is a ruling by the California Supreme Court which is considered likely to encourage insured physicians to regard their interests as threatened by their uninsured colleagues on the hospital staff. In some hospitals, insured physicians are reported demanding that the names of the uninsured be posted, and are avoiding contact with them on cases.

The future of going bare has never been bright, and appears to be growing dimmer.

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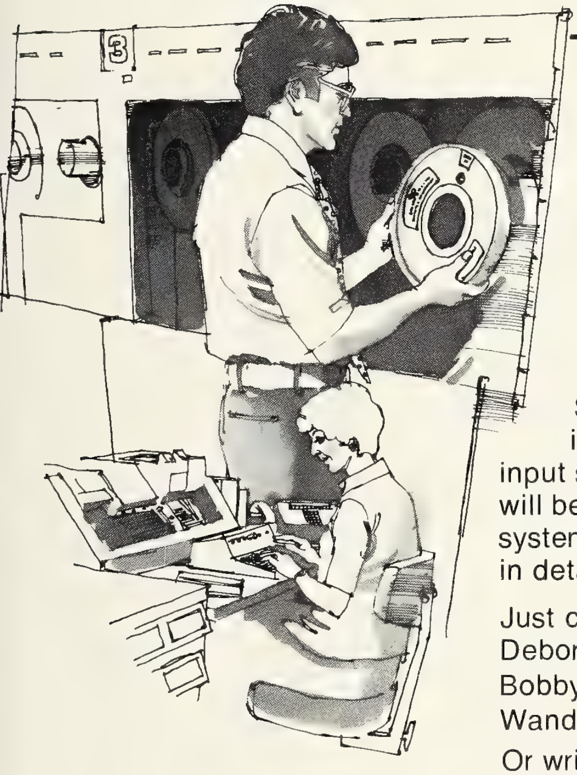

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Government interference disturbs MSMS Judicial Commission

MSMS voting members in several component societies (including Wayne County) are receiving ballots for the 1979 Judicial Commission election. The terms of three Commission members expire this year. The 10 members of the Judicial Commission, elected on a regional basis by voting members of MSMS in a mail ballot, serve three-year staggered terms.

For those who will be casting mail ballots for their Judicial Commissioner in November, and other MSMS members as well, a review of the history of the Judicial Commission and its recent activities may be helpful and interesting.

When the Commission was established by the MSMS House of Delegates in 1965, it was given broad authority to make binding interpretations of the MSMS Constitution and Bylaws and of the component medical societies, in accordance with AMA standards in matters of ethics, mediation, grievance and discipline.

The MSMS Bylaws also give the Commission the power to entertain and exercise original jurisdiction in matters pertaining to ethics, mediation, conduct of members or discipline. It serves as an appeal body for component society decisions in these areas as well.

If MSMS organization is roughly likened to that of the United States Government, the Judicial Commission would be the judicial branch; the House of Delegates, the legislative branch, and the officers, The Council and the committee structure, the executive branch.

Recent issues

The Commission has given particular attention recently to the principle of original jurisdiction. The 1979 House of Delegates considered Resolution 62-79A, which resolved that "the Michigan State Medical Society support the strengthening of county mediation, grievance and ethics committees, and that these committees meet on a regular basis and hear cases from other counties when those counties are unable to objectively deal with and conclude mediation and/or grievance action."

This resolution was not adopted but was referred to the Judicial Commission.

At its last meeting the Commission reviewed the resolution and the questions that it raised. It was the consensus of the group that component medical societies should be reminded and encouraged to establish ethics and mediation committees if they do not now have them, as required by the MSMS Bylaws. The Commission plans to encourage these committees, as well, to handle matters appropriately referred to them with due deliberation, but as quickly as possible.

Chairman John M. Malone, MD, points out, however, that if a component society is having extreme difficulty in handling a particular case, it may ask the Judicial Commission for assistance. The Judicial Commission could then either review the case itself or refer it to another component society for investigation. This approach always has been available to component societies since the Commission was established.

Doctor Malone

To bring MSMS members up to date on what the Judicial Commission has been considering lately:

The Judicial Commission has reviewed the provisions of the new Public Health Code re physician referrals to laboratories and the recent Attorney General's opinion interpreting those provisions. The Commission has not made any decision pending litigation challenging that opinion and the law.

Also being monitored is the area of physician advertising. The FTC's recent challenges to professional advertising make it difficult now for the Judicial Commission to issue guidelines for the kind of advertising that is ethical for its members, i.e., not false, misleading or deceptive, as specified in the 1977 Attorney General's opinion. The Commission might issue guidelines in the future, as suggested by the Attorney General, if they seem necessary and appropriate.

(continued on page 638)

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Increasing regulation

The Commission members have been disturbed in past months by the increasing efforts of government to regulate the ethical system of organized medicine. This trend seems to contradict the continuing demand by the public sector that medicine take care of its own offenders against medical ethics. On the other hand, the continuing climate of litigation and governmental regulations makes it more and more difficult to take direct and immediate action against those offenders. MSMS is not alone in attempting to cope with this problem, as it affects governmental agencies such as the Board of Medicine as well.

"As you can imagine, this dichotomy in public opinion — with calls for the medical profession to police itself, while laws and regulations make it increasingly difficult to do so — causes us problems," says John M. Malone, MD, Farmington Hills gynecologist and Commission chairman.

"Because of so many outside pressures, often our hands are tied," he says.

While it is not likely that this situation will improve in the foreseeable future, the Judicial Commission intends to continue to carry out its responsibilities, however, in this increasingly complex area of MSMS activities.

"Too often, I hear from other members 'You don't do anything,' " says Doctor Malone. "Outside pressures are part of the problem.

"But further, we are trying to protect physicians and not jump in with both feet, condemning them before they have their time to present their side. We look thoroughly into the complaints we receive before coming down with any decisions.

"I think the system works reasonably well with the county societies handling things first. There are delays, but they exist in the entire judicial system."

The Commission continues to refer many individual complaints against physicians to the appropriate component societies and to follow up on their disposition. Many component medical societies do outstanding jobs of handling these complaints and of enhancing the public image of organized medicine in this way.

Vice chairman of the Judicial Commission is William C. Baum, MD, a Holland urologist. Other members of the Commission are Harold A. Machin, MD, Kalamazoo; Richard J. McMurray, MD, Flint; Joseph L. Ponka, MD, Detroit; James A. Read, MD, Birmingham; George D. Stilwill, MD, Lansing; Robert K. Whiteley, MD, Grosse Pointe and George M. Wilson, MD, Marquette. MSMS Legal Counsel Stewart Kerr serves as Advisor to the Commission.

Doctors Whiteley and Wilson, who have served on the Commission since 1973 and 1970 respectively, are not seeking re-election this year. Their successors will be announced following the conclusion of the November elections.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Meet your MSMS headquarters staff

MSMS headquarters is readily accessible by telephone to every member.

But how many members have had the chance to visit the beautiful MSMS buildings in East Lansing and speak in person with those people behind the phone voices? Probably a majority of members have never had that chance.

Thus, *Michigan Medicine* begins with this issue to print photos of the MSMS headquarters staff along with their names and professional titles. Staff members will be grouped by departments.

This issue will feature the Department of Economics and Finance.

Other departments will be featured in future issues.

The Department of Economics and Finance is managed by Richard M. Campau, and includes the Bureau of Economics and the Bureau of Finance. In addition to overseeing the work of the two bureaus and the AMA/MSMS Program to Improve Health Care in Jails, Mr. Campau has direct staff responsibility for the House of Delegates, and medical care cost containment.

Bureau of Economics – John A. Richards, Chief

The Bureau has just reorganized to shift its emphasis from the gathering and analysis of economic information to focusing on the total health care delivery system. The major thrust will be the analysis of various ways physicians can organize to deliver medical care and the financing of these structures. Special attention will be paid to the various forms of pre-payment systems, including HMO/IPAs, as well as the third party payment system.

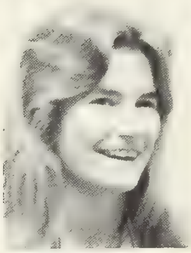
The Bureau also conducts basic research activities to assist committees implementing House of Delegates and Council policies.

Bureau of Finance – M. C. Lee, Chief

The Bureau performs complete accounting services for MSMS; Physician Service Group, Inc., and those specialty societies served by the PSG. These include the Michigan Psychiatric Society, Michigan Society of Anesthesiologists, Michigan Association for Medical Education and Michigan Society of General Surgeons. The Bureau also prepares the draft MSMS annual budget for the MSMS Finance Committee, and provides various financial reports to the director, the Finance Committee and the House of Delegates Committee on Ways and Means.

Aldrich

Campau



Jenkins

Lee

Mehler

Prichard

Richards

AMA/MSMS Program to Improve Health Care in Jails – Herbert Mehler, Project Coordinator

This program, now in its fourth year, covers 25 of Michigan's 77 county jails. The purpose of the program is to improve health care delivery systems from the time the inmate is booked into the facility until transferred or released.

Project Coordinator Mehler provides a wide range of technical assistance services to participating jails.

Also invaluable to the department's staff are Beth Aldrich, departmental secretary; Nancy Jenkins, senior accounting clerk; and Barbara Prichard, accounting clerk.

Letters

In his inaugural speech in May, MSMS President Ernest P. Griffin Jr., MD, made strong, perceptive and to-the-point statements about who's to blame and what's to be done about medical care costs.

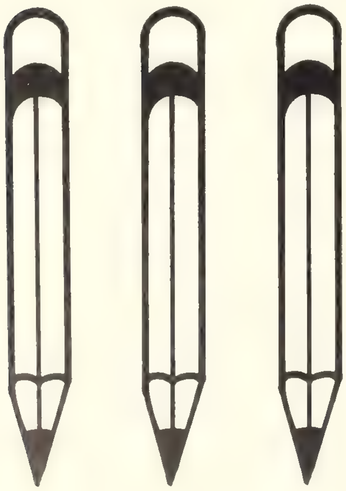
The first to hear his remarks, were the assembled MSMS House of Delegates. Since that time, his observations and recommendations have been serialized on the President's Page of *Michigan Medicine.* The June, July, August and September issues carried segments of the speech.

Doctor Griffin's observations and calls for action have evoked many responses from MSMS members. Some have appeared in this letters column over the past few months. Here is the latest:

"Doctor Griffin's . . . right on target."

Doctor Ernest Griffin's editorial in the August issue of *Michigan Medicine* was right on target. As physicians, we must clean up our own house. We have indeed made only small efforts to police ourselves as he stated so clearly.

Few physicians have made any real effort in the past, and most have been reluctant to control the costs (or quality) of medical care after the patient has gained access to the system. This reluctance on the part of physicians, individually and collectively, to accept responsibility for voluntary peer review has brought about the creation of the more structured, albeit voluntary, PSRO system.



Some doctors are inclined to view PSROs as an infringement on their freedom to practice and as another step towards socialized medicine. However, the majority of the medical profession has joined the PSRO movement. Those physicians realize PSROs represent the last chance doctors themselves have to evaluate and improve the quality and cost of the medical care they deliver.

There are many groups who would take the functions of quality assurance and cost containment out of the control of physicians. Such groups include public and private fiscal intermediaries who pay for health care, as well as many hospital administrators and other institutional providers of health care who would maintain control over the review function themselves.

Therefore, physicians, both individually and collectively through MSMS, should adopt a much stronger policy of support and defense of physician controlled quality review as performed by Professional Standards Review Organizations. We no longer merely can accept PSROs, we must be willing to stand up and be counted in support of our Congressionally mandated right to review ourselves.

PSROs are battling to preserve the right of peer review for physicians. MSMS, as the representative and leader of the medical community in Michigan, should join in this struggle to preserve these rights. This will require a team effort on the part of MSMS and the PSROs. They must both recognize the responsibility that each shares toward the development of quality medical care in Michigan.

We are confident that, seeing the need, MSMS will increasingly help gather support for PSROs and lead the battle on a statewide as well as local level.

I wish to again congratulate Doctor Griffin on bringing to the attention of Michigan physicians the need to assume responsibility for taking a critical look at the quality and cost of care which they are responsible for delivering.

Charles W. Aldridge, MD, FACOG
Medical Director
Western Michigan PSRO
Grand Rapids

"continue . . . fight against the FTC."

I would just like to add a word of encouragement to continue the fight against the FTC.

The FTC brought suit against the National Society of Plastic and Reconstructive Surgeons and even though it has cost each member a personal assessment of $350 so far, our organization has been quite successful in our stand against the FTC.

I would certainly urge the Michigan State Medical Society to continue in its fight against the FTC.

Kenneth R. Dorner, MD, FACS
Bronson Medical Center
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News

Doctor Akhter

Doctor Bender

Doctor Priver

Doctor Ruoff

By Katie Brewbaker, MSMS staff

Recipient of the John G. Wiegenstein Meritorious Achievement Award is **Ronald L. Krome, MD**, Southfield. The award is given annually to a member of the American College of Emergency Physicians in recognition of the promulgation of excellence in the field of emergency medicine.

The Michigan Academy of Family Physicians has named **Gary Ruoff, MD**, Kalamazoo, Michigan's Family Physician of the Year. In selecting Doctor Ruoff for this honor, the MAFP cited his achievements in education, work in family practice research, publication of medical papers, and medical teaching accomplishments.

Former dean of the Michigan State University College of Human Medicine, **Andrew D. Hunt, MD**, received three standing ovations recently when he was named "chairman emeritus" of the State Health Coordinating Council. Doctor Hunt has served as chairman of SHCC since its inception and also chairman of its predecessor, the State Health Planning Council.

The current dean of MSU's College of Human Medicine, **W. Donald Weston, MD**, has been singled out for special recognition. He was honored for his contributions to the development of the Upper Peninsula Medical Education Program, an innovative project for training students to be family physicians "on location" in classrooms, hospitals, and patient care facilities in Escanaba, Marquette, and other UP communities.

Team physician for the National United States Greco-Roman Free Style wrestling team at the recent World Wrestling Championship, held in San Diego, was **Fazlolah Nickhah, MD**, Ypsilanti. Following the games, Doctor Nickhah went to Turku, Finland, to attend the Fourth Congress of the International Association of Olympic Medical Officers and to present an article on "Harmful Effects of Excessive and Rapid Weight Reduction in Wrestlers."

Harold E. Crow, MD, Program Director of the Family Practice Residency Program at Sparrow Hospital, Lansing, was guest lecturer at The Mary Imogene Bassett Hospital in Cooperstown, New York. Doctor Crow spoke on "Some Thoughts on Family Practice, General and Special Systems, and an Innovative Training Model."

Douglas A. Mack, MD, Grand Rapids, is recipient of the Michigan Health Officers Association's Distinguished Service Award in recognition of his 10-year contribution to community health in Michigan and his role in developing new public health programs.

The snare drums roll and the trumpets blow their salute during the halftime ceremonies at the Traverse City Senior High School's football game, but not to usher its star athlete onto the field. The fanfare was for **G. Edward Stokes, MD**, and the cheers of the students and the fans were to

(continued on page 646)

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Roy W. Waddell, MD ORS
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thank him in a very special way for his 25 years as their team physician, former school board member, and all-around number one fan. In addition to receiving accolades and a plaque, Doctor Stokes was given the first lifetime pass to Trojan athletic events. And, to top off the evening, the team went on to win the game for their team doc.

Mohammad N. Akhter, MD, Lansing, has assumed the presidency of the American College of International Physicians, Inc. The ACIP was organized in 1975 for physicians educated in medical schools abroad who are now practicing in the United States.

The chief executive officer and executive vice president of the Rehabilitation Institute, in Detroit **Leonard F. Bender, MD,** has been elected president of the American Academy of Cerebral Palsy and Developmental Medicine.

Delmar H. Mahrt, MD, associate director of the Department of Therapeutic Radiology at William Beaumont Hospital, Royal Oak, has been named president of the Michigan Division of the American Cancer Society.

The Michigan Hospital Association has appointed **Jack Ryan, MD,** Sterling Heights, chairman of its Medicaid/Medicare Committee. The committee is responsible for formulating MHA policy positions regarding Title XVIII and XIX programs, for coordinating MHA monitoring and analyses of Bureau of Health Insurance and Department of Social Services payment methodologies and procedures.

More than 250 community leaders paid tribute to **Julien Priver, MD,** at a recent special dinner commemorating his over 28 years of service with Sinai Hospital, Detroit. Although Doctor Priver is retiring as executive vice president of Sinai, he will continue his association with the hospital as an executive consultant.

Joel Hamburger, MD, was honored during the dedication of a library-conference room at the U-M Hospital. The room, which will bear his name, was made possible through funds donated by Doctor Hamburger and will serve as a resource and conference center.

Co-authors of an article on "The Increasing Importance of Polymicrobial Bacteremia" in the September 7 issue of *JAMA* are **Doctors Daria Kiani, Edward L. Quinn, Keith H. Burch, Tom Madhavan, Louis D. Saravolatz,** and **Thomas R. Neblett (PhD)** of Henry Ford Hospital. **James C. Breneman, MD,** Galesburg, is author of "The Facial Reflex of Allergy" published in the June, 1979 issue of *Annals of Allergy*. **Errol D. Green, MD, Robert C. Zimmerman, MD, Desmond P. Colohan, MD,** and **Walid H. Ghurabi, DO,** of Lansing, collaborated in writing "Phenazopyridine Hydrochloride Toxicity: A Cause of Drug-Induced Methemoglobinemia" featured in the October, 1979, *Journal of the American College of Emergency Physicians*. **Sander J. Breiner, MD** is author of "Sexual Misconceptions" in the January/February number of *Current Concepts in Psychiatry*, "Psychological Factors in Violent Persons" in *Psychological Reports*, and "The Impaired Physician" in the August issue of *Journal of Medical Education*.

Please tear out page for year-long reference

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helps control abnormal motor activity with minimal anticholinergic side effects†

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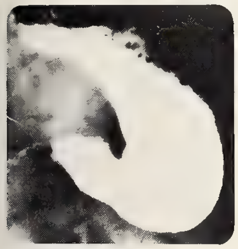
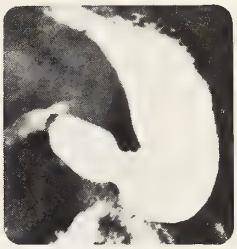
In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis, myasthenia gravis. WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS. Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with Autonomic neuropathy. Hepatic or renal disease Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur. ADVERSE REACTIONS. Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response The physician must delineate these Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations, mydriasis, cycloplegia; increased ocular tension; loss of taste, headache, nervousness, drowsiness; weakness; dizziness; insomnia, nausea; vomiting, impotence; suppression of lactation; constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs
Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water) Bentyl 20 mg *Adults* 1 tablet three or four times daily Bentyl Injection. *Adults* 2 ml (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used
Product Information as of October, 1978.

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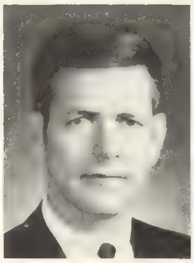

Doctor Cooksey

Come — prospect with me

By Norton J. Cooksey, MD
Northport

I'm a miner.

It's good work — challenging, exciting, and infinitely rewarding. There's always the possibility of unexpectedly striking my equivalent of the "mother lode" in any vein quarried. Unlike the legendary scarcity of Mark Twain's Californian mother lode, mine abounds; for my ore is mankind, my gold the human spirit.

My tools are few, but a working knowledge of their use is indispensable. There are the ears — they must be open to unexpected sounds, from remote places; the heart — it must be aware of its own rhythms and resonances; the hands — they must be capable of feelings beyond touch; the voice — it must remain largely silent, or be used with great sensitivity and range of emotion, and the eyes — they must transcend sight, be gentle, forgiving.

My mother lode may reveal itself suddenly, as if on the surface, in a first encounter with a stranger, or in a chance remark on a busy way with an old friend.

It may lie deep and apparently inaccessible for years, may seem to be played out, or impossible of discovery.

But in my experience the mother lode is always there, waiting to be unearthed.

Patience is required, and a kind of ultimate faith. The improbable optimism of a miner helps, but the reward of access to the finest and most enduring of the princely and plain qualities of the human soul is treasure enough.

The sadness lies in the ease with which the mother lode can be ignored, crushed, debased.

The joy resides in its discovery in unexpected places, unlikely times, in unloved or unlovely people.

Come — prospect with me.

Your tools are there, and you have ways to use them unknown to me; just as effective, just as subtle, and perhaps as neglected as mine were, for too long.

Come — the time for mining is now.

Doctor Cooksey is on the staff at Leelanau Memorial Hospital.

Primary care physicians should know how to help families of abused, neglected children

By Kimball Austin Miller, MD
Ann Arbor

Evaluating a child and its family for suspected child abuse/neglect is a rather unique aspect of the delivery of pediatric health care. It forces the primary care physician to focus on a clinical problem that violates one of his most cherished stereotypes, the loving and caring parent. The physician must be the advocate both for the child, to protect him/her from further maltreatment, and for the family, whose members need rehabilitation and family counseling. As members of the helping profession, primary care providers can decrease the pervasiveness of childhood maltreatment in this country and return a balance and harmony to the child's environment and the family.

As primary care providers, family physicians will have contact with the millions of children who will be maltreated this year. In order to act as responsible professionals, physicians must be knowledgeable of the child protection laws in their respective states (available from local medical society or state Department of Social Services).

Most state acts mandate physicians who suspect child abuse and/or neglect, to notify the Department of Social Services immediately by telephone and to file written documentation within a designated period of time. These acts also give immunity from civil and criminal liability to physicians who report in good faith as advocates for the child and require that the identity of the reporting person be kept confidential except with the consent of that person or by judicial process.

Steps to take

In order to fulfill this legal obligation and provide coordinated optimal medical care, the physician should follow a logical medical evaluation/management protocol, which might include the following classifications:

- Physical Abuse
- Sexual Abuse
- Psychological Abuse
- Physical Neglect
- Medical Care Neglect
- Intentional Drugging
- Educational Deprivation
- Abandonment and/or Lack of Supervision

The physician also should take specific steps to develop a history/physical examination/laboratory report/case disposition.

Beyond developing an overview of child maltreatment, this article sets forth a pragmatic approach for the evaluation and management of child abuse/neglect by primary care physicians of child abuse/neglect. It is important the physician use an evaluation protocol to give evidence and testimony in court. Testimony not thoroughly documented is considered only alleged history.

The list of items below must be carefully followed to provide complete and substantial testimony:

History of suspected child abuse and neglect

A) Verbatim description of how injury/abuse/neglect occurred (date, time, place, person, body site) as stated by the child and by the parent or caretaker.

B) Review of the child's health maintenance status, nutrition history, accident/ingestion history, and behavior-developmental level.

Doctor Miller

C) Review of child's medical history including major medical problems, hospitalizations, surgery, emergency room visits, and medications.

D) Record the parent's child rearing/discipline beliefs.

Physical examination/laboratory evaluation of suspected child abuse and neglect

A) A careful, complete exam, well documented for legal purposes with emphasis on recording all visible injuries (old and new) as to size, tenderness, shape, site, color, pattern (i.e. belt mark, loop mark) with the child's description of the cause of each injury.

B) Record the child's interactions with adults and specific observations of parent-child interactions.

C) Laboratory evaluations as indicated by history and physical exam which could include radiological trauma screen (especially in children under age 2 years), bleeding disorder screen and color photography.

After a thorough history, complete physical examination, laboratory evaluation and consultation with the Department of Social Services and local child protection team, the physician has two disposition options: a)

(continued on page 656)

Doctor Miller is with the Department of Family Practice and Pediatrics, University of Michigan Medical Center, Ann Arbor.

How Midland Hospital Center determined an HMO couldn't improve on utilization

By William H. Straub, MD
Midland

Cost has now dwarfed accessibility and quality as the major medical care consideration.

Competitive, alternative delivery systems in the form of HMOs have been proposed to deliver quality care at a lower cost than our traditional fee-for-service third-party system.

HMOs achieve their savings through reduced hospitalization rates. But how do we know they really will reduce costs in each community?

An analysis of the hospital utilization rate/1,000 population for the general population, corrected to exclude the Medicaid and Medicare groups characteristically not served by HMOs, may be an easy yet valuable means of evaluating the efficiency of the medical staff practice patterns in each community as well as the potential for an HMO in that site.

Recent analysis of those figures in Midland suggests that the current system can perform responsibly in regard to costs, even in the absence of a competitive system.

Some background

Midland is a small industrial town of 35,000 with a single major employer (Dow Chemical Co.), a single community hospital of 300 beds, and a medical society of approximately 100 physicians that is identical to the hospital medical staff.

The physician/population ratio is near the state average with a recent analysis by Touche-Ross suggesting a relative shortage of primary care physicians, not unlike the rest of the country. A "Physician Referral Service" is available to assist newcomers to find a physician and accessibility is not a major problem. Quality of care is monitored closely in the hospital setting by active audit committees and the staff is proud of its relatively low average length-of-stay of 6.4 days.

Doctor Straub is chairman of the Medical Cost Review Committee of the Midland County Medical Society.

Cost of care has recently become an issue in our community with Dow expressing concern over its ever-increasing bill for medical benefits, which Dow indicates soon will approach the cost of its retirement programs. Dow recognizes that a major reason for its high medical costs has been its generosity in providing ever-increasing medical and dental benefits without deductibles or controls on utilization.

Industry, when faced with this dilemma, must hold or reduce costs by 1) *reducing benefits* to employees (very unlikely where unions exist) or 2) inducing physicians to restrict utilization of costly hospital services — the HMO technique.

Data affecting costs at the Midland Hospital Center include:

Occupancy (average)	80%
Average length of stay	6.4 days
Cost per day	$230
Inpatient Days/1000 Population	834

(HSA data for 1976)

The cost per day and average length of stay in our hospital are at least average. But the notable and most important factor affecting total cost is reflected in the *hospital utilization rate* as indicated by the inpatient days/1,000 population, which considers both admission rate and average length of stay.

The 834 days in Midland compares with a state average of 1,149 days and a regional average of 1,351 days. These data are for the general population and include Medicare patients.

It is natural that a major employer consider an HMO or other "alternative system" to combat rising medical costs. But when doing so it needs to look at the potential for reducing the *hospital utilization rate* as the primary means of saving dollars.

Doctor Straub

HMOs are *pre-paid* plans in which the plan is at risk financially for the economic consequences of the practice patterns of the participating physicians. As such there are built-in incentives for plan physicians to limit hospitalization and use of Lab and X-ray services as a primary means of cost-savings almost solely by reducing hospital utilization rates.

HMOs have significantly lower utilization rates than comparable Blue Cross Plans (400-600 vs 800 days/1,000 population) for enrollees *excluding* the over-65 age group, which we know to have the highest admission rate and longest length of stay (about twice the average).

Midland rate low

If the hospital utilization rate for Midland is corrected to eliminate the Medicare group (30 percent of MHC patient days), it shrinks from a low 834 days to 584 days, which is well within the range achieved by HMO techniques. An HMO could improve little if any on this record!

The low hospital utilization rate in Midland is figured with data collected prior to current increased peer pressure for "cost containment," and is simply a result of "practicing good medicine."

(continued on page 656)

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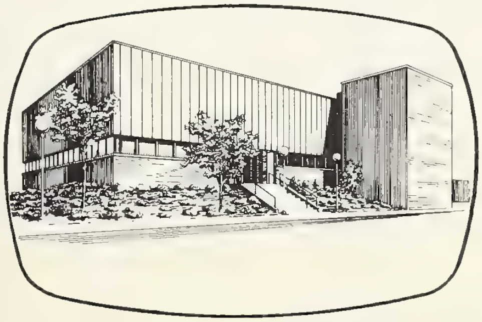

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VIEWS/*continued*

release to a responsible person (identified in your records) with Department of Social Services supervision, or b) hospitalization for further evaluation and determination of management plan. The choice should be a group decision by all professionals involved, to use community resources and family counseling to keep the family together while not putting the child at risk for further abuse and/or neglect.

Phases of problem

In order to provide optimal care, the physician must be aware of the spectrum of maladaptive parent-child interactions. This spectrum of what is considered maltreatment differs with time, culture, and the existing norms and mores of society.

Furthermore, the physician's personal past experiences, subjective theories and the social and cultural differences between the physician and parent can bias the determination of childhood maltreatment. Some practices that we now consider maltreatment were accepted previously as parental prerogatives, economic necessities, or as proper disciplinary actions which parents felt not only were their right, but their obligation.

Survey data show that violence towards children is prevalent in this country. Six percent of the respondents in a 1975 national sample who had children in the three-17 years age group reported at least one violent episode (spectrum of slapping or spanking to threatening with a weapon) during the past year, and 7.3 percent reported at least one violent episode during the rearing of their child.

This maltreatment exists in all races, religions, socioeconomic groups and family-household units (two natural parent family, natural parent/stepparent family, single natural parent family, non-natural parent family) with an etiology derived from a combination of environmental, economic, psychological and family relational factors.

Time to act

The child maltreatment syndrome is not an isolated or single disease entity, but is one facet of maladaptive family interactions which affect not only present family members, but future generations. It is not the goal of the physician to define the absolute minimal standard of "good-enough parenting," but to meet the challenge of implementing effective screening and evaluation programs, and coordinating rehabilitation programs for all parties of this syndrome.

Research of the last decade shows that a coordinated multidisciplinary (medicine/social service/mental health/legal) approach is effective in helping the great majority of these troubled families.

Being that 1979 is the International Year of the Child, all primary care physicians should commit themselves to helping all families with parenting difficulties, with the goal that every child should meet his physical and psychological potential.

DOCTOR STRAUB/*continued*

Certainly this experience is not unique to Midland. It surely would be of value if other community hospital medical staffs could analyze *their* utilization rates (days/1,000 population) as a relatively simple means of comparing their practice patterns with regional, state or national norms.

The hospital utilization rate is a much more valuable parameter to look at when *total* cost is considered than is average length of stay which does not reflect the admitting practices of the staff.

Monitoring care and cost in the ambulatory setting is "another ballgame" and the trend toward more ambulatory care is both appropriate and certain to continue.

We should not over-react to alternative systems, such as HMOs, though there will certainly be situations where HMOs, or IPAs, may be appropriate.

The federal and state governments, major employers and the "Blues" are all promoting HMOs. It is likely that every community in our state of over 25,000 will be analyzed as a "potential HMO site." Since HMOs achieve their cost-savings through reducing hospital utilization it is essential that each medical community be aware of the utilization rate/1,000 population at its hospital or hospitals as a relatively easy means of assessing the potential of an HMO.

Careful evaluation of each local situation is suggested, however, before federal funds and personal effort are expended to change or disrupt what may already be an effectively functioning system.

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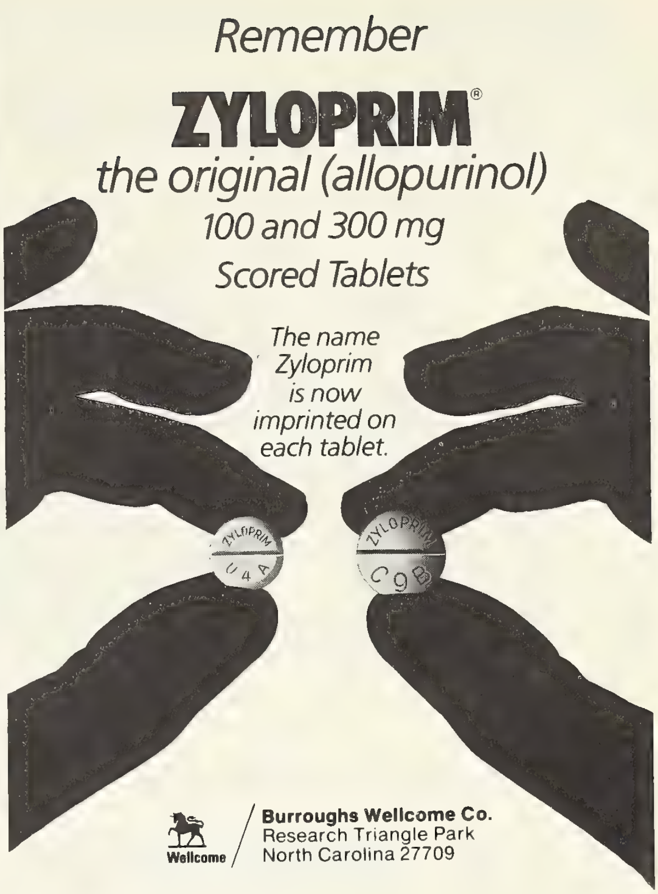
At a recent MSMS Council meeting, new Michigan Department of Mental Health Director Frank M. Ochberg, MD, left, was honored at a special reception. Among MSMS leaders greeting Doctor Ochberg and welcoming him to Michigan was MSMS Council Chairman Louis R. Zako, MD, right. Doctor Ochberg was profiled in a special *Michigan Medicine* article published in the October, 1979 issue.



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Vital statistics

The following tables are taken from recent publications of the AMA's Center for Health Services Research and Development. They are printed here to help Michigan physicians have current health care statistics at their fingertips.

TABLE A

FEDERAL AND NON-FEDERAL PHYSICIANS BY ACTIVITY AND SPECIALTY GROUP, December 31, 1977

Activity Specialty Group	Total* 100.0%	Federal Number	Federal Percent	Non-Federal Number	Non-Federal Percent
Total Physicians	363,619	19,926	5.5	343,693	94.5
Total Patient Care	332,393	16,648	5.0	315,745	95.0
General Practice	53,724	1,662	3.1	52,062	96.9
Medical Specialties	94,071	5,133	5.5	88,938	94.5
Surgical Specialties	97,359	3,937	4.0	93,422	96.0
Other Specialties	87,239	5,916	6.8	81,323	93.2
Medical Teaching	6,673	524	7.9	6,149	92.1
Administration	11,954	1,518	12.7	10,436	87.3
Research	9,786	1,020	10.4	8,766	89.6
Other	2,813	216	7.7	2,597	92.3

*Excludes 28,363 Inactive, 18,350 Not Classified, 10,946 Address Unknown, 5,790 Temporary Foreign
Note: Percentages may not add due to rounding.

Source: Center for Health Services Research and Development
Physician Distribution and Medical Licensure in the U.S. 1977
Chicago: American Medical Association, 1979

Average Net Income from Medical Practice by Specialty, 1970-1978[a]

Specialty	1970	1971	1972	1973	1974	1975	1976[c]	1977	1978[c]
Total[b]	$41,800	$45,300	$47,200	$48,600	$52,000	$56,400	$59,500	$61,200	$63,000
General Practice	33,900	39,800	41,300	41,900	44,700	45,400	47,400	51,200	52,400
Internal Medicine	40,300	42,900	44,700	47,800	51,400	57,000	60,500	61,500	64,300
Surgery	50,700	54,000	56,000	57,200	60,500	68,200	73,200	74,000	75,800
Pediatrics	34,800	38,500	38,900	41,200	42,100	44,300	47,000	48,200	50,400
Obstetrics-Gynecology	47,100	51,100	53,200	55,400	61,700	63,300	65,800	69,900	70,600
Psychiatry	39,900	37,200	39,100	38,500	41,300	44,800	47,600	48,200	49,000
Anesthesiology	39,400	47,300	49,500	48,100	54,400	57,100	60,100	65,500	67,000

[a] Because of differences in sampling procedure, figures may not be consistent with previously published data for some years; [b] Physicians whose specialties were classified as "Other" are included in this total; [c] Projected by respondents.

Source: Periodic Survey of Physicians, 1970-1978. Center for Health Services Research and Development, American Medical Association.

(continued on page 660)

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VITAL STATISTICS/*continued*

Blue Shield of Indiana has released the following information to Michigan and other states involved. The information came from HEW's Health Care Financing Administration, which published a 1978 Medicare Directory of Prevailing Charges.

1978 PHYSICIANS' PREVAILING MEDICARE CHARGES
A Comparison of Five States

	Ind.	Ill.	Ohio	Mich.	Ky.	Five State Average
Initial Limited Office Visits	$17.36-(3)	$20.61-(5)	$16.52-(2)	$19.95-(4)	$15.81-(1)	$18.05
Routine Hosp. Visit	10.26-(1)	11.67-(4)	11.16-(3)	12.48-(5)	10.60-(2)	11.23
Radical Mastectomy	539.26-(1)	614.88-(4)	637.84-(5)	591.93-(3)	541.72-(2)	585.12
Insert Pacemaker	642.30-(1)	991.25-(5)	784.69-(4)	766.67-(3)	720.70-(2)	781.12
Appendectomy	294.02-(1)	332.96-(5)	332.12-(4)	294.68-(2)	306.90-(3)	312.11
Hernia Repair	303.06-(4)	320.60-(5)	229.36-(3)	272.08-(1)	273.86-(2)	279.79
Complete Blood Count	7.25-(2)	7.86-(3)	7.89-(4)	6.00-(1)	7.25-(2)	7.25
Hysterectomy	569.31-(2)	613.10-(5)	599.06-(4)	588.15-(3)	514.56-(1)	576.83
Cataract Operation	573.17-(3)	627.61-(5)	556.73-(2)	585.05-(4)	542.80-(1)	577.07
Cholesterol Lab Test	6.00-(2)	6.22-(3)	6.32-(4)	5.00-(1)	6.58-(5)	6.02
Blood Sugar Lab Test	5.75-(2)	6.04-(3)	6.32-(5)	4.00-(1)	6.00-(4)	5.62

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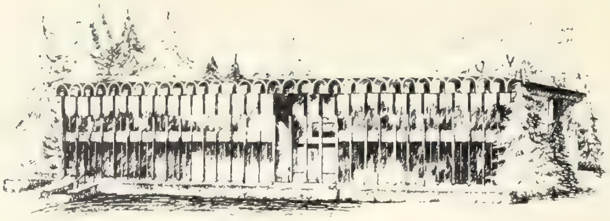
Deaths



Herbert G. Bacon, MD
Scottville

Herbert G. Bacon, Jr., MD, Scottville, died August 30 at the age of 57. He received his MD from Wayne State University School of Medicine in 1946. Doctor Bacon was a member of the staff of Paulina Stearns Hospital. He served as Chief of Staff at Paulina Stearns Hospital in 1961 and as Chief of Staff at Memorial Hospital of Mason County in 1971.

Charles J. Berger, MD
Royal Oak

Charles J. Berger, MD, Royal Oak, died August 31 at the age of 57. Doctor Berger was Medical Chief of the Division of Maternal and Infant Care for the Michigan Department of Public Health. He received his MD from Wayne State University School of Medicine in 1945. He was a diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Surgeons and a founding Fellow of the American College of Obstetricians and Gynecologists. He was an active member of the MSMS Committee on Maternal and Perinatal Health.

William N. Braley, MD
Highland Park

William N. Braley, MD, Highland Park, died Sept. 20. He was 93. Doctor Braley earned his MD from the University of Michigan. He headed the pediatric staff at Highland Park General Hospital and was the health officer of Highland Park for more than 30 years.

Norman H. Harebottle, MD
Lansing

Normal H. Harebottle, MD, Lansing, died Sept. 7 at the age of 58. He earned his MD in 1956 from the College of Medical Evangelists in California. Doctor Harebottle was a past president of the Livingston County Medical Society. He was associated with Edward W. Sparrow and St. Lawrence Hospitals at the time of his death.

Alberta Kazarian

Oakland County Medical Society Executive Assistant Alberta Kazarian died Aug. 15 at the age of 52. Miss Kazarian had been with the Oakland Society for nearly 20 years. Previous to that, she had been a medical assistant to a Detroit cardiologist and medical records librarian at Grace Hospital, Detroit and in Tucson, Ariz. OCMS President Marvin L. Starman, MD, and Executive Director Mary Sue Meyer eulogized Miss Kazarian in the September issue of the OCMS *Bulletin*.

Irving S. Katzman, MD
Southfield

Irving S. Katzman, MD, Southfield, died Sept. 15. He was 79. Doctor Katzman received his MD from Detroit College of Medicine in 1925. He was Deaconess Hospitals' first resident doctor and later, during the 1950s, was chief of staff.

Wheeler H. Kern, MD
Garden City

Wheeler H. Kern, MD, Garden City, died Sept. 19 at the age of 77. He received his MD from Wayne State University School of Medicine in 1933. Doctor Kern was an organizer of the Wayne County General Hospital.

C. Ray McCorvie, MD
East Lansing

C. Ray McCorvie, MD, East Lansing, died Sept. 11 at the age of 83. Doctor McCorvie earned his MD from the University of Toronto Medical School in 1921. He was affiliated with Edward W. Sparrow and St. Lawrence hospitals in Lansing until his retirement in 1967.

Reed M. Nesbit, MD
Davis, CA

Reed M. Nesbit, MD, Davis, CA, died August 30. He was 80. Doctor Nesbit headed the University of Michigan urology section from the time it was established in 1930 until his retirement from the University in 1968. He earned his MD from Stanford University in 1928. Doctor Nesbit received many awards during his career, including the American Association of Genito-Urinary Surgeons' Barringer Medal for outstanding achievement to genito-urinary surgery, the American Urological Association's Ramon Guiteras Medal and Award, and the Republic of China's Order of the Brilliant Star of China. The latter was awarded for a secret mission to Taiwan in 1962 to perform emergency surgery on the critically-ill Chiang Kai-Shek, head of the Republic of China.

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The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

SPACE AVAILABLE for Family Physician in two man office in Grand Rapids, Michigan. Office located in small shopping mall with easy parking. Four examining rooms, lab., and office with shared waiting room, office, and lounge. Excellent schools and friendly community with new art museum, music hall and civic theater. 616-452-1491.

DIRECTOR OF OBSTETRICS/GYNECOLOGY — Saginaw Cooperative Hospitals, Inc. is seeking a certified Obstetrician/Gynecologist with subspecialty training, and interest in both undergraduate and graduate training. Undergraduate program is affiliated with Michigan State University, College of Human Medicine. Residency program is accredited for four years of graduate education. Research opportunities available. Salary and fringe benefits are competitive. We are an Equal Opportunity Employer. Interested qualified applicants should contact: Thomas Cinque, MD, Saginaw Cooperative Hospitals, Inc., 1000 Houghton Ave., Saginaw, Michigan 48602, Telephone: (517) 771-6878.

WANTED: Full-time Staff Physician for 350-bed accredited Hospital providing rehabilitation, psychiatric and chronic disease services. General practice or internal medicine training and experience beneficial. Successful candidate must have Michigan License. Excellent salary and fringe benefits. Submit qualifications to: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, MI 48605.

FOR SALE: 3 year old family practice — Southwest Michigan — efficient operation, computer billing — grossed 140K last year — Ob optional — night coverage available for solo — ideal for compatible two-man group — owner leaving July for residency. Call collect (616) 673-5085.

OPHTHALMOLOGIST RETIRING. Wants to sell building and practice. Excellent Real Estate Investment. In practice 31 years. 95% Collection Rate. Located Jacksonville, Florida, Gateway City to Florida, and *it's largest!* Call (904) 398-0354 after 8:30 p.m.

OB-GYN SPECIALISTS DESIRED. Enjoy the security of group practice with the freedom of independent practice. If you are Board Certified or Board Eligible in OB-GYN, we have an interesting opportunity for you. One or two specialists are needed immediately to form an independent OB-GYN practice in a very desirable Northern Wisconsin Community with a drawing population of 65,000. Active practice assured. All major specialists available for consultation. Business advice, technical and legal, will be provided. Outstanding personal benefit programs available. Income potential great. Generous starting income guaranteed. A 35 million dollar hospital just opened with available office space. For further information call (715) 842-3202, or write Mr. Lloyd Engstrom, P.O. Box 1646, Wausau, WI 54401.

WANTED: GENERAL PRACTITIONER to join well-established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Rose-Jensen-Manabat, 621 E. Walnut Street, Green Bay, WI 54301. Telephone 414-437-4366.

FAMILY PRACTICE — MIDWEST — Private practice opportunity with established nine man group near modern accredited hospital. Must be Board Eligible or Board Certified and do OB. No weekend call. Excellent referral centers and continuing Medical Education in adjacent city, family oriented suburban location. Reply with curriculum vitae in confidence to: MSMS, Box 17, 120 W. Saginaw, East Lansing, MI 48823.

OPHTHALMOLOGIST — Board certified/eligible to associate with Ophthalmologist in large Anterior Segment surgical practice. Can do Anterior Segment surgery as well as general ophthalmologic practice. Please forward Curriculum Vitae to Box 16, MSMS, 120 W. Saginaw, East Lansing, MI 48823.

WANTED — 1 or 2 family physicians to take over my office and practice so I can retire. This is a large office with 4 examining rooms and 2 consultation rooms and an adjoining dental office. Occupancy in 1980. We badly need family physicians in Jackson. Address: John W. Rice, MD, 421 McNeal Street, Jackson, Michigan 49203.

GENERAL PRACTICE OPPORTUNITIES — In a small town in South Central Michigan. Good schools, hunting, fishing and many other recreational activities. Rapid rise to full partnership for the right physician. Mostly family medicine, some surgery and obstetrics. Contact W. B. Long, MD, P. C. at telephone number 517-568-4481. 9 am to 5 pm Monday thru Friday.

AM SEEKING AN ASSOCIATE IN FAMILY PRACTICE. Will turn over practice to you in four to five years or less. Location in Western Michigan. For details contact MSMS, 120 W. Saginaw, Box 15, East Lansing, MI 48823.

MEDICAL ONCOLOGY FELLOWSHIP currently available for one or two years at the Edward W. Sparrow Hospital, Lansing, Michigan. Emphasis on clinical training with research opportunities. Prefer applicant to have completed two years of Internal Medicine training. Send Curriculum Vitae to Frances A. Breen, Jr., M.D., Director of Medical Oncology, Edward W. Sparrow Hospital, 1215 East Michigan Avenue, Lansing, Michigan 48909. A Non-Discriminatory, Affirmative Action Employer.

POSITIONS WITH STATE OF MICHIGAN — Currently taking applications for positions expected to be available in several months. Primarily interested in board certified or board eligible internists, orthopedists, and psychiatrists. Office locations at Lansing, Oak Park and Traverse City. Salary in mid 50's with approximately 23% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, M.D., Chief Medical Consultant, (517) 373-7330. In Michigan, call toll free 1-800-292-2710.

Positions wanted

ANESTHESIOLOGIST BOARD ELIGIBLE — Relocating, all types of anesthesia, including Obst., open heart — prefer group — can work with CRNAS — available immediately. Contact Subbarao Narepalem, MD, 5219 West 52nd Street, Cleveland, OH 44134.

Miscellaneous

FOR SALE — X-ray picker 300 MA (Used). Fluoroscopic/Radiographic unit with image intensifier and electric rotating table. Packed ready to be

shipped. Best offer takes all. You haul it. Call 616/962-6111.

FOR SALE: DELUXE INCOME-PRODUCING CONDOMINIUM — Prestige in-town Birmingham, MI location, close library, P.O., shopping. 3-bedroom, 2-bathroom, second floor unit with carpeted outside balcony. Carpeted throughout except kitchen. All drapes and lighting fixtures, almost new side-by-side refrigerator and Hotpoint dual microwave/conventional cooker. Dishwasher and disposal. Bathrooms beautifully foil papered and mirrored. In A-1 move-in condition. 40-unit complex of steel and concrete construction. Resident manager. Closed circuit TV security and entrance control system. 2-elevators, central heat/air/TV antenna. Residents clubroom, spacious parking facilities and other amenities. Currently leased until May 31, 1980 at $959 monthly. Offered at appraised value of $125,000. 20% deposit holds until January 1980 closing. Outstanding mortgage at 8.5% can be assumed. Write Thompson, 3181, Bayou Sound Road, Longboat Key, FL 33548. Principals only please.

TRAVERSE CITY MICHIGAN — Plenty of glass, magnificent modern 4 bedroom, 3 bathrooms, 2 fireplace home, living room, dining room, family room overlooking Lake Leelanau on Timberlee ski resort. Weekly or monthly, open December thru April. Call Cindy Thompson 313-882-7060 or write 16840 E. Warren, Detroit, MI 48224.

METAL PLAQUE — Honorary certificates, diplomas, photos, etc. perfectly reproduced in bright silver toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 × 12 for only $39.95. Allow four weeks. Perma-Plaque, 553 Lincoln, Grosse Pointe, Michigan, 48230, 313/884-9399.

LIVONIA — 7 Mile and Merriman medical building, 1350 Square Feet. Customized Suites. Immediate Occupancy. 478-2121.

MEDICAL AND DENTAL OFFICE under construction — Tremendous growth location, 16 Mile just east of Ryan Road, Sterling Heights. Available soon. Call B. Monast at 313/542-7100.

Patient education programs' time has come, MDs should lead

Nearly 70 percent of Michigan nursing homes have well-developed patient education programs, according to a recent study completed by Donald J. Breckon, PhD, professor, Health Education Department, Central Michigan University, and Donald Tavano, PhD, associate professor, Department of Community Medicine, Michigan State University.

There are many advantages to such programs for physicians as well as patients, point out the two professors. They urge physicians to take the leadership in local institutions and urge development of patient education programs.

Among the advantages to physicians, they point out, are:

1. Patient education has the potential to improve the prognosis of the patient. Patients' emotional well-being often demands answers to their questions, and information they have not asked for.

2. Patient education has the potential to reduce malpractice suits. It has been established that the patient has a "right to know" in addition to "need to know." Clearly, it is no longer permissible to quickly go through a consent form. Obtaining a signature is no longer enough.

The scope of litigation in this area has dealt with informed consent per se, but also with the patient's right to information in his medical record, and his right to adequate self-care procedures upon discharge from the hospital. Clearly, there is much to commend a patient education program with the patient's progress written into the medical records.

While informed consent is primarily the responsibility of the physician there is some experience with delegating the informational part of a patient education program. The physician obviously would have reviewed and approved the material to be presented.

The patient's right to know also has been emphasized in a "Patient's Bill of Rights," accepted by the American Hospital Association in 1972. Five of the 12 statements deal directly with the patient's right to know. While patient education won't resolve the malpractice issue, it has the potential to reduce such suits.

3. Patient education has the potential of improving compliance with physician orders. Many patients simply do not follow their doctor's orders. Much of the responsibility for this situation goes back to a lack of complete understanding of what should be done and why. Most patients need full and thorough explanations of the procedures they are to follow, both verbally and in writing. Research does suggest that patient education programs increase the rate of compliance.

4. Patient education has the potential to reduce total health care costs per patient.

5. Patient education has the potential to improve patient attitudes toward health care system.

"The AMA has strongly endorsed patient education programming," Doctors Breckon and Tavano point out. "Patient education is an idea whose time has arrived. Now is the time to follow the lead of the AMA and be in the forefront of preventive medicine programming.

"Technical expertise usually is available. All that is normally needed to initiate such a program is a health educator with expertise."

President's page

Somebody is looking over your shoulder

Our careful work in keeping medical records is most important if we hope to be successful in reducing the number of medical malpractice cases.

In addition, care and good records will help our own professional liability insurance company work better for us.

The Michigan Physicians Mutual Liability Insurance Company was created by us physicians during the early days of the medical malpractice crisis.

At that time, one of the stated reasons for forming the Company was that careful evaluation of all incidents and cases of litigation would furnish the medical profession with definitive information concerning the events that resulted in law suits.

Our insurance company is still young, and there is insufficient data to present an in-depth study. The MPMLC Risk Management Committee is studying the cases and is compiling material which will address specifics in the various areas of medical practice. From time to time, your MPMLC will issue preliminary reports.

Let's call this column a preliminary report, as it includes an important message for all of us. You may laugh and sneer at these remarks but I remind you that when pilots are made aware of a dangerous trait, the solution is "back to basics." I hope you heed the message.

We can improve our records and there is evidence that it will make a difference. To date, on the basis of good, succinct records, there are several instances when litigation has been dropped or not instigated. In some cases, however, the process has gone as far as pre-trial depositions just to allow the physician to interpret his or her records. Two outstanding deficiencies have been noted:

Legibility: It does not require any additional time to write legible entries in your office and hospital records. The Plaintiff Attorney only has his client's story and litigation often is avoided when the attorney becomes aware of an accurate and legible evaluation of the events.

Specificity: This is most important. Date and time are often crucial. The precise chronological presentation of the medical events during the course of treatment or hospitalization will withstand any attack.

Recording events as they occur speaks for excellent medical care. The record precludes reconstruction of events at a much later date which always results in much dialogue and questions concerning the accuracy of the statements.

The latter is a question for the jury which the plaintiff attorney needs to get to the court house. Events must be delineated in specific terms, including negative findings.

Ernest P. Griffin, Jr., MD
MSMS President

This bars the accusation that findings were present at an earlier time and the physician did not recognize them. A good example might be found in a fracture dislocation of the spine when no neurological notes were made at the time of the original examination. Try to prove that he was a paraplegic when you first saw him, if you have not noted it in the record.

The importance of the need for clear, complete, written records is underscored in the "Views" section of this magazine by young Doctor Kim Miller of the U-M Department of Family Practice and Pediatrics.

Doctor Miller describes the need for careful description of injuries and verbatim transcripts of victims' accounts in suspected child abuse cases, if the physician's testimony is ever to hold up in court.

Again, I emphasize, for legal purposes: keep clear, complete, up-to-date medical records. You will be glad, should your day in court ever come, that you did. You and your professional liability insurance company will benefit.

Just remember that every time you write your records, "Somebody is Looking Over Your Shoulder."

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

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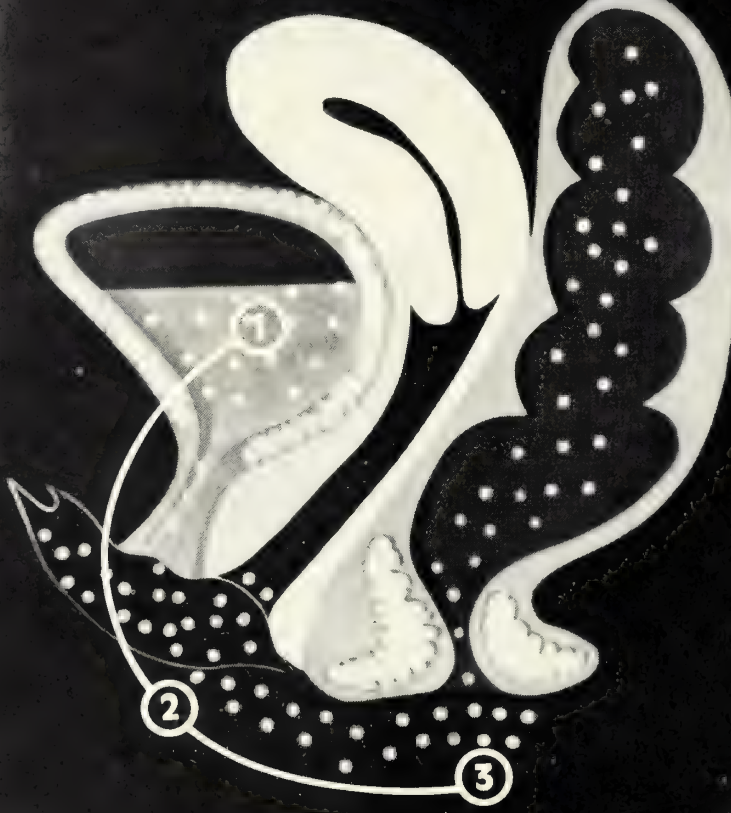
Her next attac

the Bactrim™ 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introi colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

PSULES

HE JUST-COMPLETED ANNUAL
MS SCIENTIFIC MEETING was a
sounding success if attend-
ce figures, smoothness of
eration, course evaluations
d general comments mean any-
in- at all," declared Samuel
Mahon, MD, Chairman of the
ent. "I was extremely pleas-
with the attendance, the
neral caliber of the pres-
tations, the exhibits, the
cellence of the speakers and
e general cooperation and
thusiasm of the MSMS staff
d the hotel personnel."
tal attendance passed the
000 mark. All exhibit space
s sold and the new facilities
the Hyatt Regency were pleas-
t surroundings in which to
ld the meeting. MSMS staff
now busy tabulating the
aluations and making arrange-
nts for the planning commit-
e meeting which will begin
eparations for the 1980
eting in January.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 33 NOVEMBER 30, 1979

Physicians needed for Cambodian refugees

Interested in a brief humanitarian stint serving Cambodian refugees? Frederick Minkow, MD, Bloomfield Hills, is spearheading an effort to enlist physician financial and voluntary service assistance for the refugee cause. Two organizations offer short term service possibilities. The ideal volunteer is someone with a good general medicine background. Volunteers are not paid for their services but the organizations provide transportation, living expenses and training on tropical diseases. In addition to general medicine, the groups need dermatologists, general surgeons, dentists, nurses and public health workers. One program offers a three-month experience; the other offers a one-month hitch. A one-month service tour will leave for Indo-China Jan. 28, and is seeking volunteers. Physicians interested in volunteering or making a tax-deductible financial contribution should send a note to Frederick Minkow, MD, c/o MSMS, 120 W. Saginaw, E. Lansing, 48823, or call (517) 337-1351 and ask for Mert Scholten.

ORDER FORM FOR NEW MSMS ROSTER OF MEMBERS

e 1980 MSMS Roster of Members will be published early in the year and will contain both
phabetical and county listings. Each MSMS member is entitled to one free copy but must
der below to receive a copy. Additional copies for MSMS members are $10 each. Non-MSMS
mbers, health related associations, medical schools, libraries and government departments
y purchase copies at a cost of $25 each. The cost is $100 each for "for profit" corp-
ations. Please tear off this form (your current address is on the back) and mail to
MS, 120 W. Saginaw Street, East Lansing, MI 48823.

________ I am an MSMS member. (No charge for first copy.)

________ I am an MSMS member and wish to purchase _____ additional copies at $10 each. Enclosed is my check or money order for $_____.

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________ I am with a "for profit" corporation. I wish to purchase _____ copies at $100 each. Enclosed is my check or money order for $_____.

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MAR 21 1980

CAPSULES/continued

MICHIGAN PHYSICIANS SHOULD note a change in the medical license reregistration. The relicensure form mailed is color-coded to indicate whether the renewal is for one, two or three years. On every form is a box to check testifying that the physician has earned the required 150 hours of CME credits in the previous three calendar years. Physicians are reminded of their obligation to maintain adequate proof of CME credits earned in the event of being asked by the Board of Medicine to furnish evidence of such CME credits. Please do not request a change in renewal status to one year instead of three since it is not possible to grant such requests. By 1982 all licenses will be three year licenses with one third of the licensees up for renewal each calendar year.

THE MICHIGAN PHYSICIANS MUTUAL LIABILITY COMPANY has a new quarterly newsletter going to all policy holders. The "Mutual Monitor" will notify insureds of new company policies; advise them of trends in medical malpractice litigation, law and insurance, and illustrate loss control techniques. Candace Worthington is editor.

More jails added to MSMS project

Ten more Michigan jails will be participating in t fourth year of the Michigan Jails Project Group. Sheriffs, administrators, physicians and nurses fr these jails have been invited to participate in a Dec. 18 workshop at MSMS to learn more about the p ject and the procedures involved in becoming accre ed for delivery of health care to inmates. A physician and a nurse from currently accredited jails will serve as consultants during the workshop. Janice Howard, AMA consultant, will also attend to provide expertise from the national level. A forma announcement of the ten new participating jails wi be made at the time of the workshop.

MDPAC changes membership contribut

The Michigan Doctors Political Action Committee Bo of Directors, at its fall meeting, took an unpreced ed action in its 18 year history by requesting an increased contribution from all physicians. Effec 1980 the sustaining member contribution request ha been raised to $150 from $100 with $50 being forwa to the American Medical Political Action Committee support of federal candidates. $50 for regular me ship with $25 being forwarded to AMPAC. You will be receiving your 1980 MSMS dues billing, included this statement is the MDPAC contribution request. Contributions should be written on PERSONAL check, state and federal income tax credits or deductions permissable on your political contributions.

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East Lansing, Michigan 48823

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Editor: Judith Marr

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CPSULES

TE SEVEN COUNTY HEALTH PLAN-
NNG ADVISORY COMMITTEE, com-
pised of representatives of
te MD and DO societies in
suthheast Michigan, met on
Nv. 19 to discuss the pro-
psed hospital bed reduction
pan developed by the HSA.
Aso present at the meeting
wre representatives from the
Cmprehensive Health Plan-
nng Council of Southeast
Mchigan (CHPC-SEM), the
Geater Detroit Area Hospital
Cuncil, Cottage Hospital and
te Detroit Medical Society.
Te seven county committee
spported the efforts of CHPC-
SM to keep the bed reduction
panning at the local level,
bt expressed grave concerns
bout the appropriateness of
te evaluations. The committee
flt the plan contained a bias
ainst smaller community hos-
tals which is not justifiable
the basis of cost or quality
care and decided not to
spport the bed reduction plan.
Te meeting was chaired by
mes Fryfogle, MD.

MS ATTORNEYS are conducting
massive search of FTC doc-
ents in their most recent
forts related to the FTC
mplaint against the state
dical society. Members of
e legal counsel staff are
aveling in shifts to Wash-
gton D.C. to go through some
0,000 documents contained in
file drawers in FTC offices.
ter two weeks of effort as
is Medigram was going to
ess, the attorneys had the
sk one-quarter complete.
ey estimate their research
FTC files will continue
rough the month of January.
e search is being conducted
hopes of discovering mate-
als to use in combating the
C's complaint of alleged
legal activities by MSMS in
gards to Blue Cross Blue
ield of Michigan.

BREAKING NEWS FOR MICHIGAN DOCTORS
Michigan Medicine
Medigram
VOL. 78, NO. 34 DECEMBER 14, 1979

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House passes Blues reform bill; Senate Commerce Committee has it

House Bill 4555, the major piece of medical insurance legislation this session, easily passed the House of Representatives and was referred to the Senate Committee on Commerce this week. The bill would reorganize BCBSM by reducing and altering its board of directors and require the giant health corporation to develop a cost containment program in concert with MSMS, the Michigan Hospital Association and other appropriate providers.

Under the bill, the Blues board is reduced from 47 members to no more than 31. At least three fourths of the board must be made up of consumer/subscriber members. There also would be two public members--one appointed by the insurance commissioner and the other by the Office on Aging. Board members will have to receive board agendas and detailed minutes must be kept of meetings, which must be open. The Blues claim these provisions create a conflict of interest by allowing government personnel to appoint board members while also serving as regulators, and leave board members open to legal harassment.

The required cost containment plan is given two years to work. Bill sponsor Rep. David Hollister (D-Lansing) said only if the plan fails to meet its goals could the state exercise its regulatory powers. The bill includes a formula stressing the maximum amount the cost containment plan can allow prices to rise. The formula ties increases to the annual inflation rate and to the rate of real economic growth. Also allowed will be a senior discount on health care rates, something the Blues claimed will force their subscribers to subsidize senior citizens by up to $20 million a year.

Those speaking to the bill said it will reduce government regulation of the Blues if the health insurance company can meet health care cost containment goals, and will make the organization more consumer oriented.

PHYSICIANS ARE RESPONDING beyond expectations to a Nov. 30 Medigram call for volunteers to travel to Southeast Aisa to aid Cambodian refugees. So much interest has been expressed that an entire contingent of Michigan health care personnel may be formed. Further information is available from Mert Scholten at MSMS headquarters.

CLOSE TO 1,500 orders have been received at MSMS headquarters for the 1980 MSMS Roster of Members. The roster is scheduled for distribution in January and will contain a listing of MSMS members by component society memberships and also by alphabetical order. Those who have not placed orders may fill out forms which appear in the Nov. 13 and Nov. 30 issues of Medigram. Additional forms may be obtained from MSMS headquarters.

COMPLETE DETAILS and a registration form for the 1980 Michigan Conference on Maternal and Perinatal Health will appear in the January issue of Michigan Medicine. The conference is scheduled March 5-6 at the Hyatt Regency Dearborn. Information is available from Katie Brewbaker at MSMS headquarters.

AMA House acts on FTC, medical education, LCCME

The future of medical education was the priority
at the 1979 AMA House of Delegates interim meetin
2-5 in Honolulu. A return to something akin to t
old rotating internship was strongly advocated.
AMA Council on Medical Education's report, "The F
of Medical Education," will be an "agenda for dis
sion" over the next several years, and as such, t
House accepted the report. It now becomes a majo
thrust for AMA for the next several years. MSMS
bers will receive a copy of the report in the com
months.

The AMA House also placed the AMA in favor of fed
legislation that would remove 20 professional org
izations, including organized medicine, from the
purview of the FTC. This legislation, known as
the McClure-Melchior amendment, failed to progress
in 1979, but will be an item of discussion in the
Congress of 1980.

The House also reaffirmed its determination to di
from the LCCME and to continue to conduct its own
accrediting functions.

Physicians may sign up now for Physicians Legislative Network

MSMS members have an annual opportunity to visit
legislators and government executives by signing
for the 1980 Physician Legislative Network. The
plication form appeared in the Nov. 13 Medigram;
also may be obtained from Gary Anderson at MSMS h
quarters. One, two and three-day stints in Lansi
for physicians and spouses begin Jan. 21 and run
consecutive weeks.

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

MICHIGAN MEDICINE

Vol. 78 No. 34, December 14, 1979

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Editor: Judith Marr

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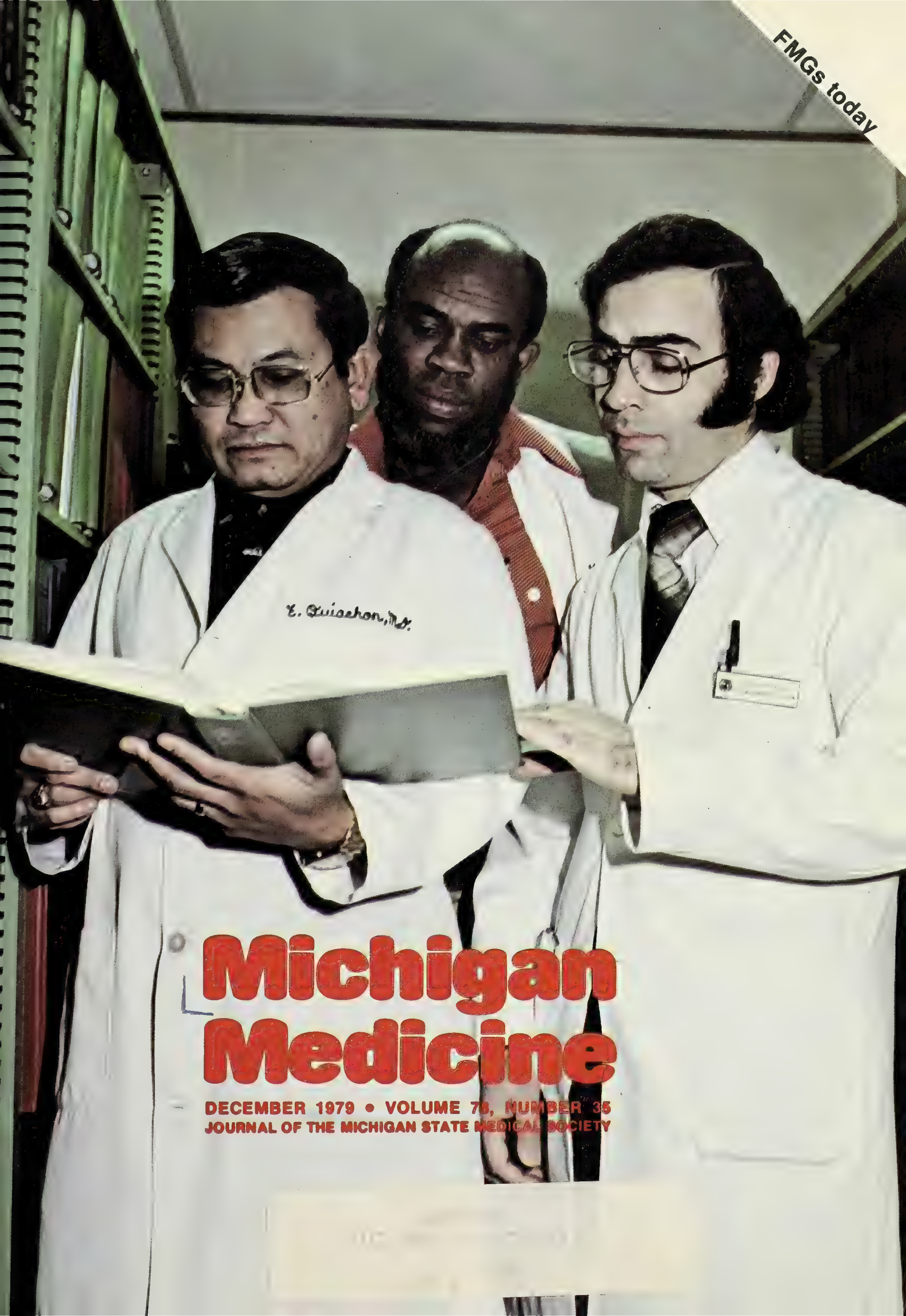
FMGs today


E. Quisahon, M.D.

Michigan Medicine

DECEMBER 1979 • VOLUME 78, NUMBER 35
JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

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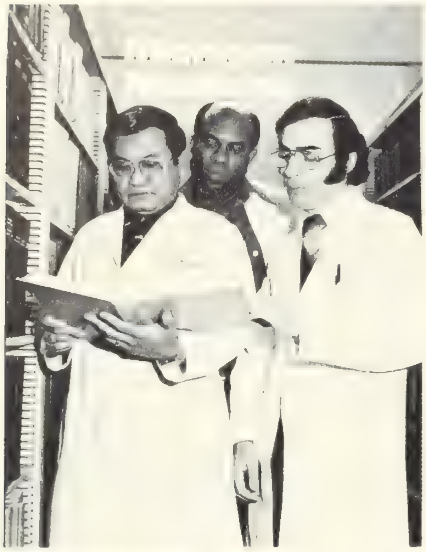
Contents

December 1979, Volume 78, Number 35

Michigan Medicine



Foreign medical doctors have contributed much to the medical scene in the United States. Typical of Michigan's international mix are Ernesto B. Quiachon, MD, the Philippines; Ajovi Scott-Emuakpor, MD, Africa; and Abdel Salhab, MD, Palestine, all of whom are on the staff of Ingham Medical Center, Lansing.

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

Special Section

667 **With the number of FMGs entering the U.S. cut drastically in recent years, a rational system is needed to allow a reasonable influx of foreign-trained physicians;** Shelton Reece, Arthur J. Griggs, MS, Arthur J. Lewandowski, PhD, and Moon J. Pak, MD, PhD

Features

672 **IPAs and other HMOs major topic of MSMS Public Affairs Conference**
678 **Michigan's government: Part one of a major new *Michigan Medicine* feature;** Gary Anderson
680 **Lansing's Health Central shows HMOs, health care delivery competion are here;** Charles R. Downs
682 **Meet MSMS Department of Government Relations staff**
689 **Legislative profile: Rep. David Hollister;** Willah Weddon
696 **Kent County Medical Society;** R. Jack Chase, MD
705 **Maternal Health Desk Reference Card #23**
709 **How one FMG adjusted;** Hugo R. Saenz, MD

Departments

688 **Health Planning Update**
697 **Welcome**
700 **Business**
702 **News**
710 **Ad Index**
714 **Category I courses**
716 **Meetings**
720 **Deaths**
722 **Classified**
724 **President's page**

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Needed: A reasonable system for FMGs to study, work in U.S.

By Shelton Reece
***Special to* Michigan Medicine**

Foreign medical graduates (FMGs) have filled a vast void in the health care delivery system of this nation.

Yet the emotion generated by "the FMG phenomenon" led to imbalanced reporting by the lay, and some of the professional, media. Such reporting by people with only cursory knowledge of the subject often portrayed FMGs as inferior to U.S. physicians.

Nevertheless, FMGs have contributed immeasurably to health care manpower in the U.S. Other contributions are evident at varying levels.

Because of changes in supply and demand, FMGs, until recently, largely entered programs in non-university or non-affiliated institutions in which their service contributions to patient care far exceeded the education they received.

Their contributions to medical research have not been measured, but a look at scientific journals over the past two decades reveals increasing contributions by names which are uncommon in North America. Scholarly writings and acquisitions of Nobel Prizes for work done in this country reveal FMGs' academic achievements. Additionally, increasing numbers of FMGs have become involved in the teaching of medical and health care professional students.

FMG defined

A foreign medical graduate, as defined by Yvan J. Silva, MD, FRCS (C), FACS, Professor of Surgery, Wayne State University School of Medicine, Detroit, is a physician whose degree or diploma was conferred by a medical school outside the U.S., Puerto Rico, or Canada.

Using that definition, the birthplace or nationality of an FMG is of no significance. A citizen of the U.S. who received a medical degree in a country other than the U.S., Puerto Rico, or Canada is classified as an FMG. A non-U.S. physician who acquired such a degree in the United States is not.

Doctor Silva is the author of the book *Career Development for Foreign Medical Graduates in the United States*, and a member of the Board of Trustees of the Educational Commission for Foreign Medical Graduates.

One of the best informed persons in the country on FMG history, problems, and opportunities, he states that the FMG situation has changed drastically through the years, basically because of the medical needs of the States and the needs of individual physicians who want to study and/or practice here.

"Traditionally," Doctor Silva says, "young physicians have wanted to study in countries recognized for their excellence in medicine. Early in the 20th century, it was important for young American physicians to study under European physicians.

"With rapid advancements made in the U.S. in virtually every area of medicine and science this trend reversed, bringing increasing numbers of foreign doctors here. The goals of the earliest students were to train and to return home. But brighter prospects existed in the U.S. and foreign doctors immigrated until a full-scale annual influx began in the 1950s.

Michigan provided many positions for FMGs. It now ranks third in FMG population, following New Jersey and New York.

"The influx of FMGs was made possible by relatively liberal U.S. government immigration policies. It was stimulated, from the '50s to the '70s, by approved U.S. graduate training opportunities far in excess of domestic graduates. For example, in 1971, U.S. medical schools graduated 8,974 physicians. In the previous academic year, a total number of 15,534 internship positions were available, a deficiency of almost 100 percent."

Doctor Silva

Legal status

The U.S. Information and Educational Exchange Act of 1948 included physicians in the Educational and Cultural Exchange Program. In 1961, the program was modified by the Fulbright-Hays Act. It permitted non-immigrant status in the U.S. during graduate training and required the FMG to return to his home country. These exchange visitors entered as non-immigrants with a "J" visa and were permitted adjustment to immigrant status only when the regulations were waived on an individual basis of exceptional hardship.

In April 1970, the Immigration and Nationality Act was amended, enabling holders of the "J" visa to adjust to immigrant status provided no financial assistance had been received from the U.S. or their country of nationality or last residence. This encouraged a large number of FMGs to remain in the U.S.

So many remained that by 1973 one-third of all hospital staff physicians and one-fifth of all doctors in this country were FMGs. One year later, statistics revealed that 18.6 percent of all full-time teachers in U.S. medical schools were FMGs.

"But not all FMGs were so successful," Doctor Silva points out. "The difficult process of evaluating FMGs in the context of their ability to receive graduate training here was delegated to the Educational Council for Foreign Medical Graduates (ECFMG)."

ECFMG rules

Created in 1956 by the American Medical Association, American Hospital Association, Association of American Medical Colleges, Association for Hospital Medical Education, and the Federation of State Medical Boards of the U.S., the ECFMG developed an examination given semiannually since 1958.

"With rare exceptions, graduates of medical schools outside the U.S., Puerto Rico, and Canada who wish to come to this country for graduate medical education, or for other types of medical practice, must hold a certificate issued by the ECFMG. In almost all cases this certificate is issued only after a candidate has successfully passed the ECFMG exam," Doctor Silva explains.

"The exam, though very fair, is extremely difficult and, of course, not all FMGs who take it score passing marks."

It was not until early 1971 that the U.S. Labor Department required an ECFMG certificate, or other proof of eligibility, for appointment to the staff of a U.S. hospital for all physicians seeking a preferential immigrant visa.

The inappropriate regulation of the FMG influx into the U.S. led to the presence of many thousands who are unable to contribute to the medical manpower pool because they failed the ECFMG exam. It is known that many of these FMGs work in nonprofessional jobs, while many "moonlight," actually performing professional duties under cover of misleading job descriptions.

DISTRIBUTION OF RESIDENTS BY SPECIALTY AND RESIDENT FMGs WITH J VISA 1978

Specialty	Total Residents	FMGs	% FMG of Total	FMGs with J Visa	% of FMGs with J Visa
TOTAL	62,992	9,699	15.4	2,489	25.7
Anesthesiology	1,872	722	38.6	140	19.4
Child Psychiatry	237	86	36.3	33	38.4
Colon & Rectal Surg.	24	8	*	8	*
Dermatology	639	26	4.1	11	42.3
Diagnostic Radiology	1,165	169	14.5	42	24.9
Emergency Medicine	2	0	*	0	*
Forensic Pathology	7	2	*	2	*
Family Practice	5,366	253	4.7	22	8.7
General Practice	229	201	87.8	27	13.4
Gen. Preventive Med.	68	5	*	1	*
General Surgery	7,220	1,453	20.1	544	37.4
Internal Medicine	15,080	1,615	10.7	307	19.0
Neurology	1,016	200	19.7	78	39.0
Nuclear Medicine	101	42	41.6	17	40.5
Neurological Surg.	504	114	22.6	76	66.7
Obstetrics-Gynecology	3,940	613	15.6	158	25.8
Occupational Medicine	15	5	*	1	*
Ophthalmology	1,385	69	5.0	14	20.3
Orthopedic Surgery	2,179	175	8.0	55	31.4
Otorhinolaryngology	798	121	15.2	45	34.7
Psychiatry	3,615	919	25.4	155	16.9
Pediatrics	4,878	917	18.8	181	19.7
Public Health	29	3	*	1	*
Physical Med. & Rehab.	314	169	53.8	26	15.4
Plastic Surgery	327	52	15.9	34	65.4
Pathology	2,288	692	30.2	225	32.5
Radiology	1,357	331	24.4	83	25.1
Therapeutic Radiology	225	115	51.1	28	24.3
Thoracic Surgery	219	53	24.2	37	69.8
Urological Surgery	935	203	21.7	96	47.3
Unspecified	2,383	279	11.7	16	5.7
Other	5,961	87	1.5	26	29.9

*Less than 10 observations
Source: Center for Health Services Research and Development, American Medical Association, Chicago, March 1979.

Doctor Silva states that things have changed greatly in the last few years, partially because U.S. medical schools are producing more physicians (15,300 persons received MDs in 1978), while the number of training positions has decreased. Also a law effective as of January 10, 1977 states that physicians who apply for immigration after that date cannot be granted preferential visas. That law also requires physicians to return to their own countries after two years of study in the U.S.

Pendulum swings

"The pendulum has swung so far regarding foreign medical graduates that by next year probably only about 1,000 FMGs will enter the country. Unless some definitive changes are made, there is a real likelihood that none will enter by 1985," comments Doctor Silva.

"I believe it would be very unfortunate if our laws became so restrictive that the U.S. failed to help educate physicians trained in other countries where their services desperately are needed. Such physicians not only serve the health needs in their countries, but also add to the overall advancement of medical knowledge. Sharing knowledge is always beneficial to all concerned.

"With systematic dialogue between organized medicine and the U.S. government, there should be some equitable way to allow a reasonable number of FMGs to come into the country to study and, if needed, for some of them to stay, if they so desire. Such dialogue is in progress."

MSMS-originated program offers FMGs needed educational opportunity

By Arthur J. Griggs, MS
Arthur J. Lewandowski, PhD
Moon J. Pak, MD, PhD
Rochester

The FMG manpower pool has played a major role in meeting the health manpower needs of the country at a time of rapidly growing social/health care awareness.

In the course of events, however, many foreign-trained doctors were recruited to fill training programs of marginal quality, where the service function of physician training far outweighed the educational function. Many state and city hospitals, especially mental institutions, hired these physicians lacking adequate medical education and frequently even lacking medical licensure. Rarely were there any opportunities for a meaningful cultural orientation program or assistance to develop fluency in the English language.

Quality educational opportunities have not been available to many FMGs who have been incorporated into this pool of FMG physicians, either.

The situation is improving, however. While FMGs in the past immigrated here to supplement the manpower pool, the current legislation places the FMG in a different context — that of the physician-in-training. This "training" pool of FMGs should be exposed to quality medical education programs that will ultimately lead to improved health care delivery in the home countries to which these physicians will be returning.

Foreign Medical Graduates residing in this country are, without doubt, faced with a difficult challenge in becoming practicing members of the medical establishment. Those physicians who are unable to pass the required examination for training or licensure in a reasonable time are left in a position where little assistance is available to help them attain their ambition. Unless a drastic change in an individual's approach to the examination is made, little hope exists for ever succeeding. As time passes, the fundamentals that were learned in medical school begin to fade or become out-dated, and the struggle becomes increasingly frustrating.

Addressing needs

Michigan's increasing dependence upon FMGs for physician manpower during the past decade brought with it a concomitant increase in the number of individuals facing the perplexing situation described above.

The Michigan State Medical Society in 1974 confronted the problem head on and, in a move that must be considered precedent-setting, decided to fund a program that would provide a review of medical education to physicians in the state preparing for the ECFMG examination. Under the aegis of Oakland University's Center for Health Sciences, a proposal to conduct an eight-week review course during the summer, 1975, was submitted and subsequently approved.

The problems that were being confronted in Michigan were prevalent in other parts of the nation. It was not surprising, then, that the federal government also made a commitment to assist those FMGs already in this country and practicing medicine under temporary, partial, or institutional licenses or permits. HEW's Bureau of Health Manpower, Division of Medicine, requested proposals in May, 1975, for the development of a comprehensive medical review program for the FLEX (Federal Licensing Examination).

Expanding on the proposal that was prepared for the Michigan State Medical Society, Oakland University submitted a proposal which was subsequently funded. Nineteen months were spent in developmental activities which culminated in a three month comprehensive review course which was implemented in February, 1977.

Class characteristics

It is interesting to look back now at the characteristics of the class of students who participated in that FLEX review program and examine the impact which the course had on their examination success.

As stipulated by the grant contract, only non-fully licensed, fully-employed physicians working in various health care settings could be admitted to the program, with the exception of bona fide refugees. Out of a total of 454 application requests, 72 physicians were admitted and completed the program in its entirety. The mean age of the class was 46.7 years, with two-thirds men and one-third women. The majority were married (67%), and the average number of years residing in the United States was 14. Forty-five different medical schools were represented by the class. The average number of years since graduation from medical school was 18.6, and ranged from 2 to 37. Eighty-nine percent of the class reported having completed an internship and 71% had been in a residency training program.

Through the cooperation of both the students and the Federation of State Medical Boards, June, 1977, FLEX results were obtained for 59 of the 72 program participants. Sixteen of the 59 physicians passed the

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Mr. Griggs is assistant to the director, Doctor Lewandowski is research data analyst, and Doctor Pak is associate provost and director, Center for Health Sciences, Oakland University.

examination with a FLEX weighted average of 75.0 or better, corresponding to a 27.1% pass rate. Of these 59 physicians, full sub-scores were available for 50 individuals. Presumably, 13 participants did not take the June FLEX.

In terms of the impact of the program on FLEX sub-scores, a comparison of scores between June, 1977, FLEX and the most recent pre-program FLEX (available on the majority of these students) was made. Clinical science average scores and clinical competence average scores improved substantially following the program (from 68.1 to 71.4 and from 70.2 to 73.1, respectively). Basic science average scores, on the other hand, showed negligible improvement (from 61.6 to 61.9). The program effect upon the FLEX weighted average was an improvement from 67.9 to 70.8.

Predicting success

Several factors were identified as playing a role in predicting examination success following participation in the review program. The principal ones were: years since graduation from medical school, number of years in the United States, students' past test history, and type of residency training received. An interesting case was the performance on the June, 1977, FLEX by the bona fide refugee group of physicians who attended the program. This group of eleven physicians (nine Vietnamese and two Russians) presented an average age of 36 years, had been out of medical school an average of 9.5 years, and had been in the U.S. an average of 1.8 years. Despite a general lack of experience with the National Board Examination format, English language difficulties which were greater than the class as a whole, and minimal acculturation within the United States, this group achieved a FLEX pass rate of 63.6%, which is approximately 15% above the national norm for all FMGs sitting for the FLEX.

Since the grant-supported program of 1977, the Medical Review Program has been continuing on a self-supporting basis. Two twelve-week programs are scheduled per year, starting in March and in September. The lecture format (over 350 hours of instruction per program) draws upon the expertise of approximately 70 physicians and doctorate faculty from within Oakland University and the local medical community. The program content provides a review which is appropriate for both FLEX and ECFMG.

Please see related article on pages 709-710.

As a self-supporting program, the student admission process has not been governed by the "fully-employed, non-fully licensed" stipulation of the grant-administered program. Because of this, class composition has been markedly different. On the average, students have been younger and the length of time out of medical school and in this country has been shorter. As expected, the impact which the Medical Review Program has had on the recent participants is more encouraging. For the participants completing the program on June 1, 1979, an identical pass rate of 55% was achieved by those students taking the FLEX as well as those taking the ECFMG.

In describing the reactions of the FMG physician/students to the program, it is often difficult to distinguish between an individual's feelings about his total life situation and his participation in the program. A full array of attitudes have been observed, from gleeful appreciation and excitement to serious and interfering depression and frustration. Certain characteristic reactions we have come to view as expected, if not typical.

The FMG in the Review Program often views the staff and faculty as resources and support in more global terms than simply as medical information sources. Personal family and cultural concerns are often communicated to the staff who are asked for advice, help, and at times specific aid.

A second aspect observed has been a tendency for these physician/students to become compulsively tied to course materials in a possessive way. More extreme reactions of fears of materials being stolen or altered "intentionally to disrupt my studying so that I fail" have occurred.

A third notable aspect consistently occurring is the concern that test scores on the licensing examinations are intentionally manipulated to prevent the FMG from attaining full licensure. It appears that these issues intensify with repeated attempts at examination without success.

FMGs: training

The future position of the FMG in the United States should be placed in the context of the educational setting, i.e., foreign physicians-in-training should be allowed to come to the U.S. as participants of student exchange programs. They should be placed into training programs with sufficient educational orientation, such as an academic medical center or community tertiary health care center. Perhaps a quota on the number of FMGs allowed in each of the institutions would be in order. FMGs entering such training programs should be extended the courtesies granted to any other visiting scholar, including the right to pursue a training program of choice, free from the limitations of time guidelines established by the office of the Immigration and Naturalization Service. After all, these physicians will be serving as badly needed specialists, academic physicians, and researchers upon returning to their countries. Finally, the educational program for FMGs should include a measure of relevance to the type of health care delivery system that the foreign physician will be returning home to, so that what is learned in the U.S. can be readily applied abroad.

In closing

The pool of FMGs that currently reside in the U.S. and who have experienced the difficulties of entering the mainstream of our medical establishment, should also have access to educational opportunities which offer them the hope of achieving their lifelong ambition. Obviously, a traditional medical school approach would not be feasible. However, a program of the type offered at Oakland University, where a comprehensive review and updating is provided to reinforce and refresh the memory, appears to offer much that is desired and needed.

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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Second annual Public Affairs Confere

Intense interest was displayed in physician-organized Independent Practice Association type health maintenance organizations during question and answer periods at the second annual Public Affairs Conference sponsored by the MSMS Committee on State Legislation and Regulations.

Frederick W. VanDuyne, MD, Flint physician who has played a major role in the establishment and implementation of Genesee Health Care, an IPA-type HMO, was queried at length. The audience dwelled on such aspects of the IPA-HMO as quality control, abuse control, and risk sharing.

The interest of the 100 physicians present was a natural outgrowth of talks in the morning session by Congressman David Stockman and health economist Walter McClure, Ph.D. Stockman had called for physician action to help defeat HR2626, the administration's hospital cost ceiling bill. McClure had warned that the only means of overcoming governmental regulation of medical practice is through a free competitive market among alternative delivery systems.

When Doctor VanDuyne described the IPA-HMO, the audience responded with vigorous questioning, sensing it as one kind of alternative and competitive form of health care delivery.

Other speakers at the Public Health Conference were W. E. Maldonado, MD, Chairman of the MSMS Committee on State Legislation and Regulations, who reviewed the current version of the state's cost containment legislation. Doctor Maldonado asserted the bill delays regulation in Michigan, while providing the private sector an opportunity to influence the cost goals of the bill.

David Siegel, MD, Chairman of the MSMS Medicaid Liaison Committee, reviewed the activities during the life of the committee, begun in 1972 as an instrument for MSMS and the state to share problems and potential solutions.

Speakers at the 1979 MSMS Public Affairs Conference included Cong. Dave Stockman left, standing, and Walter McClure, PhD, seated.

The second conference of its type sponsored by MSMS, the meeting drew over 100 physicians to Lansing for lively and pertinent discussions of current medical practice issues.

(Please see President's page for Doctor Ylvisaker's conference remarks.)

rks IPA/HMO discussion

Following are excerpts from talks given by Congressman Stockman and Doctor McClure:

"Review, Preview and Prognostications from the Congress"

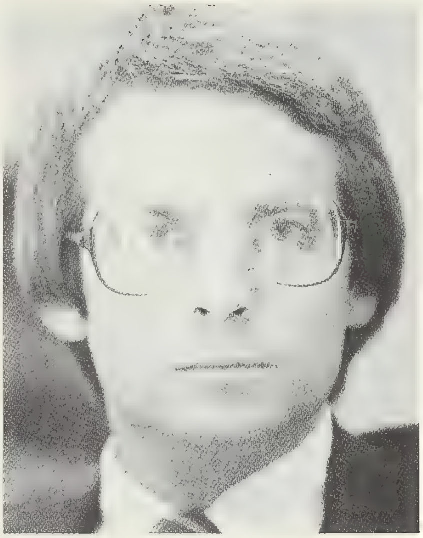
Excerpts from talk by Congressman David Stockman:

. . . if you look at PSRO or Health Planning or even the Certificate of Need process, you will see that these regulatory services haven't solved the basic problem of rising cost. The share of GNP that's accounted for by the health sector continues to enlarge, and all problems of overutilization, etc., continue to exist despite regulatory services that have been created.

So what we have now with the hospital cost containment bill is simply the ultimate step, on this whole regulatory model, reflecting the fact that the model has failed and tools that we have used to implement it have failed. So we have dropped all pretense of sublety and discrimination, such as case-by-case political decision review under PSRO or item-by-item review of investment under health planning and certificate of need. We simply slam on a spending lid, close our eyes, and hope the program will separate the wheat from the chaff. I think all you realize it will do nothing of the kind.

What I am suggesting this morning is that we need to defeat the hospital cost containment program, not only because it is a bad bill on its own technical terms and will do more damage than good, but more importantly because it implies a set of assumptions about how the health care system works and what federal policy ought to be.

If we can defeat it, we can go back to the drawing board and start over. I am not going to suggest this morning how we can start over, or what these new practices of health policy ought to be — but I would like to suggest a more productive and more effective health care policy.


Cong. Stockman

The key in my view is to recognize that the non-economic behavior of the health care system today, on which all these regulatory models and programs are premised, can be altered by reorganizing and reforming the financing mechanism which drives the whole system, from the consumer paced side all the way through physicians, the institutions, right on down the line.

Basic requirements

I think that the three basic requirements of any new approach to health care policy in this country should be as follows:

1. We need to reorganize the financing mechanism, and by that I mean third party payments, in such a way that it will transform passive consumers of health care that we have today into active shoppers for the maximum value of the dollar that they are paying for their health care plans. I think that can be done through multiple choice, both in the Medicaid system and in the private insurance plans that employers offer today.

2. We need to encourage a payment system that rewards providers for better health outcome and consumer satisfaction, and not simply the quantity of services delivered. I think that will automatically happen once we get consumers shopping for health care plans and the best value of the dollar they are spending.

3. We need a payment and financing system that puts investment incentives on institutional health care providers, whether hospitals, or nursing homes or any of the other institutions; that puts those institutions at risk for the investments they make in new capacity and new equipment and new service units — as opposed to the automatic recovery of cost regardless of efficiency, appropriateness, or utilization rates.

Active shoppers

It seems to me that if we could get active shoppers rather than passive consumers — if we could get providers who have to be cost conscious because they are facing a competitive market — if we could get investment decisions in the hospital and health care system that have some element of risk involved, thereby controlling the level of investment — we could indeed go a long way toward solving many problems that have led to this whole regulatory model and the initiatives that have sprung from it. I guess my bottom line is (to consider) alternatives to a regulatory model — in hospital cost containment, certificate of need, health planning, PSRO and to some of the even more draconian control measures that are in store for us, such as decisions of fee regulation.

The alternative to that is a model based on consumer choice and pro-

(More on page 676)

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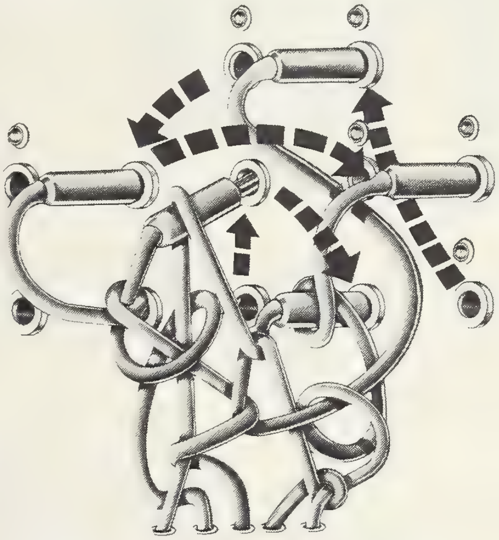

Which waiting call is an emergency?

The problem went critical with plans to consolidate these facilities and to add a new unit with space included for a mental health center.

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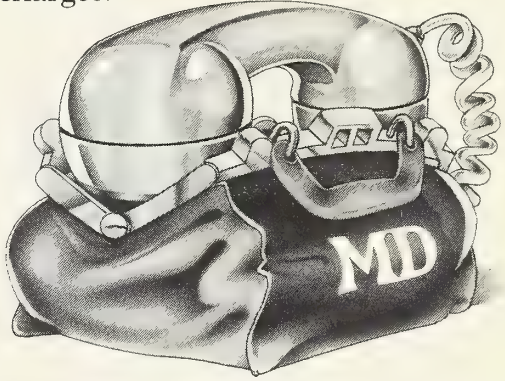
And the system saves money for Bay Medical—a healthy $51,000 the first year in operator costs alone. Furthermore, it enhances patient care, improves staff productivity, simplifies the collection of patients' telephone charges.



Calls follow doctors wherever they go.

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vider competition. Unless we can figure out how to do that very quickly, we are going to find ourselves drifting back toward the regulatory model and toward even more drastic interventions and controls of our health care institutions and of our health care professions.

Following are excerpts from "Getting Serious About Competitive Alternatives to Regulation," by Walter McClure, PhD, vice president and director, Health Policy and Planning, InterStudy, Minneapolis.

. . . Under the present system there is no reward for consumers to choose efficient providers. You could go to the most expensive hospital or the most efficient hospital, and your premium is unchanged. If you are a provider, you are penalized for being efficient. You are paid less if you order fewer, more appropriate services, and your efficiency, far from being a selling point to consumers, is irrelevant and even invisible to them.

We can change that if we create groupings of providers, among whom consumers can choose for comprehensive care, such as that the premium reflects the efficiency of the provider grouping chosen. Let us consider a health care system where providers are organized into groupings competing for consumers. Call these provider groupings "health care plans," as distinct from health insurance plans. Health care plans provide care; health insurance plans only pay for it.

Each plan can be organized in any way the participating providers wish. Thus they can include most existing professional arrangements with rather minimal modification. For example, the most organized type of plan would probably be a hospital-based, group practice HMO. The least organized might be an "alliance" of independent solo fee-for-service doctors and hospitals.

Restructure the market

. . . A provider grouping need not be tightly organized into an HMO to be efficient. Many solo fee-for-services doctors already practice efficient, conservative medicine. They could create market forces under comprehensive insurance if they would participate with selected, equally efficient colleagues in what we call a "health care alliance," which is probably the most loosely organized type of health care plan. An alliance is almost a conventional insurance plan, but with an important difference. It defines a specific set of providers accountable to provide, directly or through referral, the medical care to enrolled consumers. For the alliance to reimburse a service, the enrolled consumer must agree to go to a participating provider or to providers referred by participating providers. (To assure good choice and competition, an alliance must not be permitted to be a monopoly of every provider in town. Then it is just an insurance plan, and no economic competition among groupings of providers is created.)

***(Excerpts based on Doctor McClure's address as printed in* Pennsylvania Medicine.)**

Doctor McClure

. . . To maintain good competition and avoid possible collusion, it is important that there be a diversity of health care plans. If one is physician-run and one is consumer-run, it is hard to believe that they are going to collude on anything. Similarly, non-profit plans and for-profit plans should find collusion difficult, because they come from such different places. Likewise, group practice plans, and solo practice plans, or salaried plans and fee-for-service reimbursed plans. Competition should be good. So diversity is extremely important. It is also extremely important that there be ease of entry into the market, so that new plans can start without great barriers. The threat of new plans coming in will help keep existing plans efficient and everyone trying to satisfy the consumer.

. . . I highly recommend to physicians that you give the restructured market approach your best shot. If you can make it work, then further regulation will be unnecessary. If you don't like it, or if the American people won't buy it, then of course there will be no other course but strong regulation. But even if the market approach proves insufficient by itself to contain costs, to the degree that you have some market forces working, the regulation can be that much more minimal. On the other hand, if we go to the regulatory route first, and we don't like it, we can't resort to the market. There is little history of deregulation. It is very hard to dismantle or reorient regulation once in place.

Things to do

There are several things physicians should do to implement a restructured market approach. First, organized medicine must endorse the concept and promote it. State and county medical societies must actively espouse a private pluralistic system which includes a diversity of health care plans as well as traditional practitioners. You must discourage overt and covert opposition to new competitive plans — discourage such things as denial of hospital privileges or professional ostracism of participating physicians. You must publicize the concept so that all physicians understand what it is and why it is desirable, so that consumers see good new plans as acceptable. You need to encourage leading physicians to participate in such plans, so that the idea acquires stature and reputation. Don't leave it to the marginal members of medicine.

Secondly, you will have to promote the idea very actively to business and labor, too, because it is these people who can open the market for new plans to employees.

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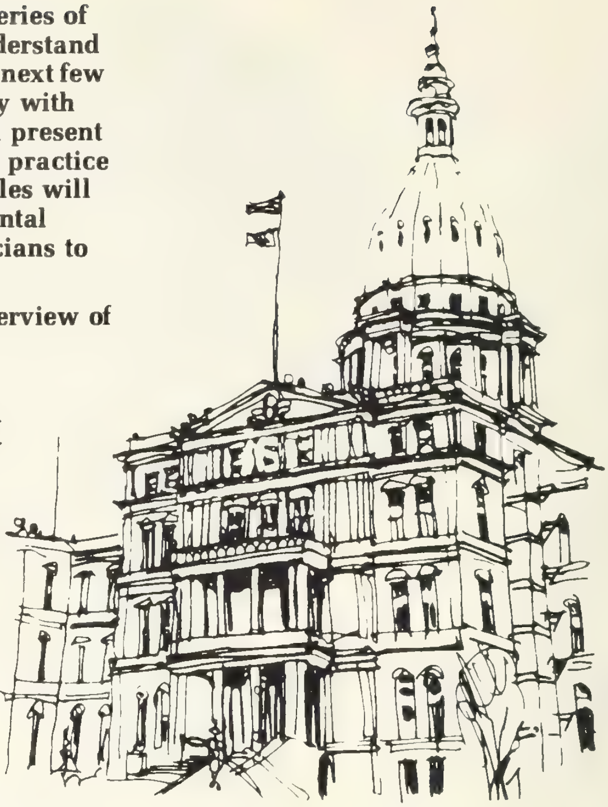
With this issue, *Michigan Medicine* begins a series of articles to help Michigan physicians better understand and work with their state government. Over the next few months MSMS staff members who work closely with various branches of Michigan government will present articles describing how government affects the practice of medicine in Michigan. In addition, the articles will describe the structure of the various governmental branches, and the avenues available for physicians to work with governmental departments.

This first article in the series presents an overview of the state government structure.



Michigan's government and you, Doctor

By Gary Anderson
MSMS Department
of Government Relations

Do government growth and the proliferation of regulations dismay you? Are you concerned about the effect government has on you and your practice?

Then you are like many other physicians who express a desire to become more involved in helping their profession cope with governmental bureaucracy. "Understanding the system" can help in dealing with government agencies in a time of rapid change.

Michigan government, like federal government, is organized into three branches; the executive, legislative and judicial. These three branches develop the framework, initiate the necessary legislation, and interpret the consensus of public policy.

In 1963 there was a dramatic change in Michigan government. With the public's approval of a new Michigan constitution, the stage was set for sweeping governmental changes. The Executive Reorganization Act of 1965 created a clear line of responsibility and activities for the heads of 19 departments of state government that were created.

These departments comprise the executive branch of government and are responsible to the Governor in formulating the executive policy for the state. They are: the Departments of Agriculture, Attorney General, Civil Rights, Civil Service, Commerce, Corrections, Education, Labor, Licensing and Regulation, Management and Budget, Mental Health, Military Affairs, Natural Resources, Public Health, Social Services, State, State Highways and Transportation, State Police and Treasury.

Not all of these departments are significantly involved with health care and medicine. However, many do include some health and medical care components.

The various departments, at the request of the Governor, develop plans for the administration of the state, coordinating their individual functions as part of an overall policy of state government. The legislature often introduces bills to assist the administration in accomplishing its objectives. More often, however, lawmakers will initiate their own legislation which they believe is in the best interest of the public.

After a standing committee of the legislature reviews and amends the legislation, it is referred to the floor of either the House of Representatives or Senate. After sometimes lengthy debate, the House or Senate will pass the bill and refer it to the other chamber of the legislature.

Once the bill has passed both chambers it is presented to the Governor to be signed into law. If, as happens on occasion, the Governor does not believe the legislation fits with his policy or is beneficial to the people of the state, he may veto it. It takes a two-thirds vote of the legislature to override a veto from the Governor. Given the usual makeup of the two-party legislature, an override vote is very difficult to obtain.

Once a bill becomes law it is then referred to one of the 19 departments where rules are promulgated to implement the law. It is at this juncture that much of the bureaucracy is activated.

Future articles in this series will explore the functions of the Departments of Licensing and Regulation, Management and Budget, Mental Health, Public Health, and Social Services. They will describe each department's organization, objectives, and effect on medicine and the delivery of health care, and examine MSMS efforts in working with regulatory processes.

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Story of Lansing's Health Central HMO has two major lessons for MDs

By Charles R. Downs
Special to Michigan Medicine
(Second of a Two-Part Series)

In 1978, Lansing's Health Central became the fastest growing health maintenance organization (HMO) on record, going from no patients to about 21,000 in a year's time. But it was too much too soon. Health Central began referring people to emergency rooms and other doctors. Expenses were not controlled and by mid-1979 the HMO was facing bankruptcy. It has now been bailed out financially by Blue Cross and Blue Shield of Michigan and appears to be recovering.

What Lansing-area physicians say they have learned from the Health Central experience is that health maintenance organizations are attractive to many people and that the private practice of medicine will have to become competitive if it wants to retain the patient following it has enjoyed in the past.

All the reasons for Health Central's large initial subscription are not clear. Some, such as Arthur Kohrman, MD, a member of the HMO's board of directors and a professor of pediatrics of the College of Human Medicine at MSU, say that there were not enough family doctors in the Lansing area and that too many people were going to emergency rooms for routine problems.

They also say that Health Central offers comprehensive, one-stop patient care, including optometric exams as well as specialist care.

While these arguments are contested by other doctors, the point on which there does seem to be consensus is that money is a major factor.

More for less

Health Central offers more services (including no-charge office visits and physical exams) at rates that are competitive with Blue Cross-Blue Shield or other health insurance plans.

Some Lansing physicians question the quality of health care provided by Health Central. But they also point to the support and encouragement that fledgling HMOs receive from state and federal governments and conclude that HMOs are going to stay on the scene and grow.

One physician who doesn't question the quality of care provided by Health Central is its medical director, D. Bonta Hiscoe, MD. He has been a Lansing area surgeon for 22 years and has enjoyed the respect of the community's physicians, as indicated by his presidency of the Ingham County Medical Society a few years ago.

Doctor Hiscoe did not join Health Central until February 1979, after it had been in operation for over a year. His directorship undoubtedly has given Health Central more respectability in the medical community than it would otherwise have enjoyed.

He says his decision was a difficult one, but notes that he had been involved in group practice, was intrigued by the challenge of administration, and was thinking about a career change that would keep him in the Lansing area.

"I didn't go in as a do-gooder," he says. "My thought was, 'Let's take a look; see if it will work.' "

At the time of the appointment, he, like the board of directors, knew nothing of the impending financial crisis that would force the departure of the executive director.

"If I had known, I would never have joined Health Central," says Dr. Hiscoe, "but I had already burned too many bridges and decided to stick it out.

"The problems of Health Central have not been in the quality of care but in business management.

"Providing health care is not easy. You have to work at it hard. It is not a job for amateurs. Some consumer-oriented people think you will automatically have a lot more for less, but it's not that simple.

"Medicine is a business and should be treated that way, whether you are involved with an HMO or in private practice and working with an insurance company.

"The Blues and I represent the professionals that are coming into the HMO movement and that is the real world."

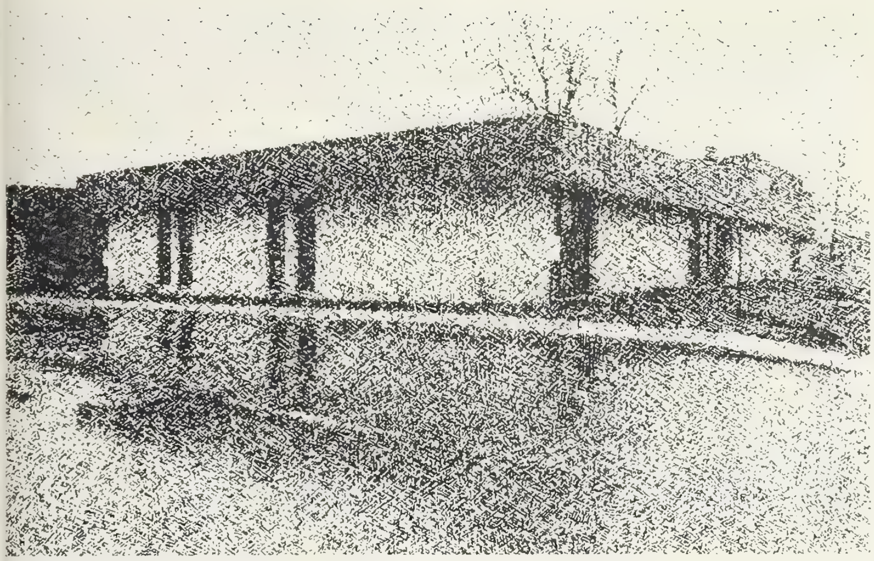
Some practices hurt

Some Lansing physicians say their practices have not been hurt by Health Central but others say they have. One of them is Richard L. Hatton, MD, president of the Capital Area Chapter of the American Academy of Family Physicians.

Doctor Hatton notes that though only 10 per cent of his patients asked for transfer of their records, he experienced a 30 percent loss of income, which he has since recouped.

He believes that the quality of medicine HMOs gives is not as good as that of private, fee-for-service practice.

"The personal interest is not the same," he contends, "and in the long run the costs are apt to be even higher."



Health Central, Lansing

For Doctor Hatton, the Health Central lesson is that people are looking for less expensive forms of medical care, and that doctors in private practice will have to find ways of competing more effectively.

IPAs an answer

One of the answers that many private physicians are advocating is the formation of HMOs called Independent Practice Associations (IPAs). In an IPA, patients go to private practitioners who provide services for a fixed amount (a capitation fee) each year. There are a number of variations in IPAs. The participating physician's income varies according to the expense of the services required by the patients.

But Doctor Hatton does not think IPAs are a good answer because, "They put costs above quality care. For example, if a patient has a hernia, the IPA model would suggest giving him a truss even though an operation might represent higher quality care."

He thinks that there are better alternatives. As AAFP Capital Area president, he has appointed an ad hoc committee to seek them in collaboration with private insurance companies.

David J. Smith, MD, of Grand Ledge heads that committee, which is currently looking at a Seattle IPA sponsored by Safeco, an insurance company. Doctors can sign up to take care of given patients or families for a year at a time for a specific capitation. If the patient needs to be referred to a specialist or requires hospital care, the private physician determines the specialist or the hospital.

"He can choose expensive ones or not so expensive ones," explains Doctor Smith, but at the end of the year, his share of the capitation fee will be affected by his decisions.

"This is different from other IPAs which have a closed panel of specialists that can be called."

Could this lead to putting costs ahead of quality care?

"I don't think so," says Doctor Smith. "There is still the argument that the malpractice threat looms as large as ever. But more importantly to me is the argument that is this system we would still have the doctor/patient relationship that we now enjoy in our fee-for-service arrangement."

HMOs in future

Regardless of whether or not this particular plan comes to Lansing, it seems likely that there will be other HMOs in the future. MDs David Siegel and B.H. Smookler of Lansing have talked of organizing a private HMO, and so has the Ingham County Medical Society.

George D. Stilwill, MD, president of the society, advises doctors to learn as much about the HMO systems as they can, and points out that several members have attended in-depth meetings and seminars on HMO planning.

"It seems to be the wave of the future, increasingly sought by industry, unions and government," he notes.

But Doctor Stilwill isn't sold on the idea of a county society running an HMO.

"Increasingly," he explained, "medical societies are being encouraged to stick to their traditional educational, ethical roles, fostering a pluralistic approach to health care delivery, rather than becoming sponsors of IPAs or other kinds of health care delivery."

Hugo R. Saenz, MD, president elect of the Ingham County Medical Society, agrees that doctors need to know more about HMOs. He is interested in the IPA concept but is against federal support for HMOs, believing they should have to compete on their own.

"HMOs," he adds, "are not a threat, if we continue to practice unselfishly."

Meet your MSMS headquarters staff

The division of Government Relations serves MSMS members by monitoring, interpreting and influencing the actions of the State and Federal government in relation to the medical profession and health care delivery.

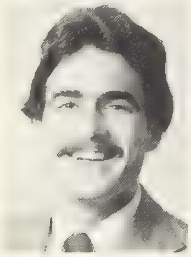
Bruce W. Ambrose directs the activities of the division as it works closely with physicians to monitor the hundreds of bills introduced in the legislature each year. Through a strong MSMS committee and legal counsel, MSMS supports legislation that will assure the professional integrity of members. Working with the MSMS Federal Legislation Committee, the division interprets the effects of federal laws and how doctors in Michigan can respond to them.

Legislative support programs, Gary Anderson's responsibility, encourage physician participation in the governmental process. The Physicians Legislative Program, formerly the "Doctor-of-the-Week" program uses the talents of individual physicians in lobbying efforts; regular component medical society meetings with legislators provide continuing contact between elected officials and local physicians; and the annual MSMS Public Affairs Conference gives physicians insight on current legislative issues from recognized experts. The Michigan Doctors Political Action Committee functions separately from MSMS. It directly affects the legislative process by supporting political candidates sensitive to the needs of organized medicine.

Ambrose

Anderson

Frost


Kelly

Paradis

Smith

Wellman

Governmental agencies inplement and regulate diverse issues and programs directly affecting physicians. Prominent examples include the Medicaid program, statewide health planning, health care facilities, provision of "basic health services," public health and mental health services, and health care personnel. Sherry Wellman interacts with the executive branch of state government tracking regulatory changes relating to medicine.

MSMS Physician/HSA Support Center activites are directed by Dennis Paradis, assisted by Kevin Kelly. Established by House of Delegates action in 1978, the Physician/HSA Support Center provides staff to physicians involved in the health planning process. The Support Center works with physician advisory committees in the regional health service areas, and provides current information about health planning issues.

Other key members of the Division are Glenn Smith, departmental secretary, and Irene Frost, secretary.

MSMS headquarters is readily accessible by telephone to every member.

But how many members have had the chance to visit the beautiful MSMS buildings in East Lansing and speak in person with those people behind the phone voices? Probably a majority of members have never had that chance.

Thus, *Michigan Medicine* continues with this issue to print photos of the MSMS headquarters staff along with their names and professional titles. Staff members will be grouped by departments.

This issue will feature the Department of Government Relations. The Department of Economics and Finance began the series in the November issue.

Other departments will be featured in future issues.

In therapy of skin and skin structure infections
due to susceptible strains of staphylococci and/or streptococci…

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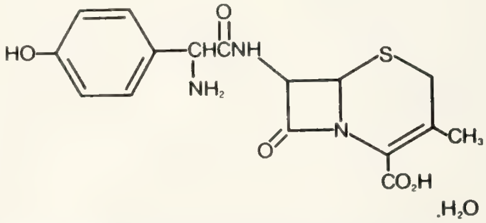
References:
1. Data on file, Mead Johnson Pharmaceutical Division.
2. Gatley MS: To be taken as directed. *J Roy Coll Gen Pract* 16:39, 1968.

DESCRIPTION: DURICEF® (cefadroxil monohydrate) is a semisynthetic cephalosporin antibiotic intended for oral administration. It is a white to yellowish-white crystalline powder. It is soluble in water and it is acid-stable. It is chemically designated as 7-[[D-2-amino-2-(4-hydroxyphenyl)acetyl]amino]-3-methyl-8-oxo-5-thia-1-azabicyclo [4.2.0]oct-2-ene-2-carboxylic acid monohydrate. It has the following structural formula:



Clinical Pharmacology–DURICEF (cefadroxil monohydrate) is rapidly absorbed after oral administration. Following single doses of 500 and 1000 mg., average peak serum concentrations were approximately 16 and 28 mcg./ml., respectively. Measurable levels were present 12 hours after administration. Over 90 percent of the drug is excreted unchanged in the urine within eight hours. Peak urine concentrations are approximately 1800 mcg./ml. during the period following a single 500 mg. oral dose. Increases in dosage generally produce a proportionate increase in DURICEF urinary concentration. The urine antibiotic concentration, following a 1 gm. dose, was maintained well above the MIC of susceptible urinary pathogens for 20 to 22 hours.

MICROBIOLOGY: *In vitro* tests demonstrate that the cephalosporins are bactericidal because of their inhibition of cell-wall synthesis. DURICEF is active against the following organisms *in vitro:*

- *Beta-hemolytic streptococci*
- *Staphylococci*, including coagulase-positive, coagulase-negative, and penicillinase-producing strains
- *Streptococcus (Diplococcus) pneumoniae*
- *Escherichia coli*
- *Proteus mirabilis*
- *Klebsiella* species

Note–Most strains of *Enterococci (Streptococcus faecalis* and *S. faecium)* are resistant to DURICEF. It is not active against most strains of *enterobacter species, P. morganii*, and *P. vulgaris*. It has no activity against *Pseudomonas* or *Herella species*.

Disc Susceptibility Tests–Quantitative methods that require measurement of zone diameters give the most precise estimates of antibiotic susceptibility. One recommended procedure (CFR Section 460.1) uses cephalosporin class disc for testing susceptibility; interpretations correlate zone diameters of the disc test with MIC values for DURICEF. With this procedure, a report from the laboratory of "resistant" indicates that the infecting organism is not likely to respond to therapy. A report of "intermediate susceptibility" suggests that the organism would be susceptible if the infection is confined to the urinary tract, as DURICEF produces high antibiotic levels in the urine.

INDICATIONS: DURICEF (cefadroxil monohydrate) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

- Urinary tract infections caused by *E. coli, P. mirabilis*, and *Klebsiella* species
- Skin and skin structure infections caused by staphylococci and/or streptococci

Note–Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATION: DURICEF (cefadroxil monohydrate) is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE.)

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil monohydrate).

PRECAUTIONS: Patients should be followed carefully so that any side-eff
or unusual manifestations of drug idiosyncrasy may be detected. If a hypers
sitivity reaction occurs, the drug should be discontinued and the patient trea
with the usual agents (e.g., epinephrine or other pressor amines, antihistami
or corticosteroids).

DURICEF (cefadroxil monohydrate) should be used with caution in the prese
of markedly impaired renal function (creatinine clearance rate of less than
ml/min/1.73M²). (See Dosage and Administration.) In patients with know
suspected renal impairment, careful clinical observation and appropriate
oratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of nonsuscepti
organisms. Careful observation of the patient is essential. If superinfection oc
during therapy, appropriate measures should be taken.

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Coombs testing of newborns whose mothers have received cephalosporin a
biotics before parturition, it should be recognized that a positive Coombs t
may be due to the drug.

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seen in reproductive studies in mice and rats receiving dosages greater than
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been established. The benefits of the drug in pregnant women should be weig
against a possible risk to the fetus.

ADVERSE REACTIONS: Gastrointestinal–The most frequent side-effect has b
nausea. It was infrequently severe enough to warrant cessation of therapy. Adm
istration with food decreases nausea and does not decrease absorption. Diarr
and dysuria have also occurred.

Hypersensitivity–Allergies (in the form of rash, urticaria, and angioedema) h
been observed. These reactions usually subsided upon discontinuation of
drug.
Other reactions have included genital pruritus, genital moniliasis, vaginitis, a
moderate transient neutropenia.

DOSAGE AND ADMINISTRATION: DURICEF (cefadroxil monohydrate) is a
stable and may be administered orally without regard to meals. Administrat
with food may be helpful in diminishing potential gastrointestinal complai
occasionally associated with oral cephalosporin therapy.

Adults–For urinary tract infections the usual adult dosage is one gm. (two 5
mg. capsules) two times per day. For skin and skin structure infections the us
dose is 500 mg. two times per day or 1 gm. once a day.

In patients with renal impairment, the dosage of cefadroxil should be adjus
according to creatinine clearance rates to prevent drug accumulation. The
lowing schedule is suggested. In adults, the initial dose is 1 gm. of DURIC
(cefadroxil monohydrate) and the maintenance dose (based on the creatin
clearance rate [ml/min/1.73M²]) is 500 mg. at the time intervals listed bel

Creatinine Clearances	**Dosage Interval**
0-10 ml/min	36 hours
10-25 ml/min	24 hours
25-50 ml/min	12 hours

Patients with creatinine clearance rates over 50 ml/min may be treated as if t
were patients having normal renal function.

Children–Dosage and safety have not yet been established in children.

HOW SUPPLIED: DURICEF® (cefadroxil monohydrate) capsules 500 mg.
oral administration in an opaque maroon cap and opaque white body No. 0 h
gelatin capsule. On each half capsule printed in black is "MJ" and "500." Availa
in bottles of 24 capsules (NDC 0087-0784-41) and 100 capsules (NDC 008
0784-42).

U.S. Patent Re. 29,164

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Getting acquainted was the order of the day at the Michigan Health Council's recent Physician Recruitment Conference held in East Lansing. More than 200 community representatives, doctors and medical residents attended the one-day session, which featured speakers, table-top displays, and a mix of towns all the way from Newberry in the U.P. to Adrian. Here, two representatives from Group Health Service, Saginaw, introduce themselves to David Kearney, resident at William Beaumont Hospital, Royal Oak.

Attention physicians: Patients needed for these U-M studies

Studies of esophageal disorders

Twenty-four hour monitoring of distal esophageal pH and motor activity is now available as a means of establishing the diagnosis of abnormal gastroesophageal reflux and atypical chest or abdominal pain of esophageal origin. This study is performed with a recording catheter inserted into the patient's esophagus (as a nasogastric tube) and connected to portable monitoring equipment. The patient is permitted to eat, drink, and ambulate and is asked to record any subjective complaints, and position at the time these occur. Symptoms are then correlated with documented abnormalities of esophageal motor function determined by the monitoring equipment. This evaluation provides the most sensitive indicator of abnormal gastroesophageal reflux and esophageal motor function currently available and is anticipated to be of great value in establishing definitive diagnoses in these often difficult to diagnose patients.

For additional information, contact Dr. Mark B. Orringer, University of Michigan, Section of Thoracic Surgery, Ann Arbor 48109, (313) 764-4177.

GnRH secretion in hypothalamic amenorrhea

The cooperation of physicians is requested in referring patients with amenorrhea of hypothalamic origin. Patients who have been amenorrheic for at least 4 months on the basis of pituitary or hypothalamic diseases are eligible. The etiology of amenorrhea following oral contraceptive therapy, after weight loss (either dieting or anorexia nervosa), after emotional disturbances, and resulting from hyperprolactinemia is unknown and the studies are aimed at elucidating the mechanisms of anovulation and amenorrhea. Patients will initially be screened to determine acceptability, and subsequent studies will involve a 7-day admission to the Clinical Research Center at University Hospital, Ann Arbor. The cost of admission and studies performed will be borne by the Clinical Research Center. Physicians interested in further details or in having their patients considered, please contact Dr. John C. Marshall, R3044 Kresge II, University Hospital, Ann Arbor, Michigan 48109.

Additional notices from the University of Michigan Clinical Research Center will appear in future issues of Michigan Medicine.

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PNEUMOVAX is contraindicated in pregnant females, children under two years of age, and in the presence of hypersensitivity to any component of the vaccine. *Adverse reactions* include local erythema and soreness at the injection site; low-grade fever occurs occasionally. *PNEUMOVAX will not immunize against capsular types of pneumococci other than those contained in the vaccine.* Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions.

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INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

PNEUMOVAX is not recommended for patients who have received extensive chemotherapy and/or nodal irradiation for Hodgkin's disease.

WARNINGS: *PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).*

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature	Pneumococcal Types													
U.S.	1	2	3	4	6	8	9	12	14	19	23	25	51	56
Danish	1	2	3	4	6A	8	9N	12F	14	19F	23F	25	7F	18C

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained. Intradermal administration may cause severe local reactions.

PRECAUTIONS: Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Caution and appropriate care should be exercised in administering PNEUMOVAX to individuals with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk and also to patients who have had episodes of pneumococcal pneumonia or other pneumococcal infection in the preceding three years and may have high levels of preexisting pneumococcal antibodies which may result in increased reactions, mostly local but occasionally systemic. Available data suggest that revaccination before three years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours' duration, occurs commonly; local induration occurs less commonly. In a study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. Low-grade fever (less than 100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination. Although rare, fever over 102°F has been reported.

Reactions of greater severity, duration, or extent are unusual. Rarely, anaphylactoid reactions have been reported.

NOTE: Administer subcutaneously or intramuscularly. *DO NOT GIVE INTRAVENOUSLY. DO NOT GIVE INTRADERMALLY.*

STORAGE AND USE: Store single-dose prefilled syringes and unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol 0.25% added as preservative.

Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded after the expiration date.

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Inject contents of syringe to effect a single dose.

Single-Dose and 5-Dose Vials
For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only; in a box of 5 individual cartons, each containing a single-dose vial of vaccine; and in 5 single-dose prefilled syringes.

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Health planning update

By Dennis Paradis, Director
MSMS Physician/HSA Support Center

This is the fourth in a regular series of health planning features planned for *Michigan Medicine* by the MSMS Physician/HSA Support Center.

State Health Plan approved

Michigan's first State Health Plan (SHP) was approved with modifications on November 6. The major amendments were the deletion of sections dealing with state-funded abortions and the provision of birth control services to "mature minors" without parental consent. The proposed cap on medical school admissions at 745 per year was a hotly debated issue. The legislature retained the 745 cap but called for a study to develop more detailed information on the supply of Michigan physicians. The State Health Plan is now the "principal guide for the development of state health programs and for the allocation of resources to health activities in this state."

State Health Plan II available for comment

Proposed State Health Plan II (expected to conclude its approval process in late 1981) is available for review at each HSA. The proposed timetable for SHP II is: public hearings in December, committee action in February and March and approval by the Statewide Health Coordinating Council (SHCC) in April. The Governor and legislature then have 60 legislative session days to review the SHP. SHP II includes substantial changes and will receive close scrutiny from the MSMS Steering Committee on Health Planning.

Health planning amendments stress competition

PL 96-79, which extends the life of the national health planning structure for three years, has added amendments to promote competition in the health care industry. The need for competition is expressed in the section on National Priorities: "The Congress finds the following deserve priority consideration . . . (17) The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve . . . to advance the purposes of quality assurance, cost effectiveness and access."

Representative Hollister's interests center on health care legislation, reform

The following article is the thirteenth in a series. The articles, written especially for Michigan Medicine by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.

By Willah Weddon
***Special to* Michigan Medicine**

The 80-year-old man made it clear he wanted to die with dignity when the time came. But life-sustaining treatments were continued when he would not have wanted them.

"My grandfather's death was very tragic," State Representative David C. Hollister said, shaking his head at the memory. "I thought about it a lot, read all I could find and then organized a 'Death and Dying' task force to work with me."

The result was a bill he introduced n the Michigan House of Representaives three years ago, now referred to as the medical treatment decision act. He reintroduced it with a few modfications this session (H.B. 4058), but a tie vote in the Public Health Committee kept it from going to the House floor last June. Hollister's convinced, however, it will be reported out of committee the first of next year and "fairly confident" the entire egislative body will give it strong approval.

Michigan bill 'best'

"This bill is unique in the country oday," the 37-year-old Lansing Democrat pointed out. "It doesn't say what the decision will be if a person becomes incapacitated. It simply guarantees that person the right to choose an agent, someone known and trusted, who will make medical treatment decisions when s/he can no longer do so."

Rep. Hollister

This signed document empowers the designated person to make treatment decisions after considering the attending physician's recommendations, the patient's previously expressed desires and other relevant factors at the time. If the proxy makes the decision to turn off life support systems, provisions under the proposed law would relieve physicians and nurses from any liability.

An editorial in the *New England Journal of Medicine*, (May 31, 1979) lauded Hollister's bill as the best of all suggested solutions to resolve the dilemma of decision-making for incompetent patients who are incurably ill.

Conceding that such decisions were made by the family and the physicians in the "old days," Hollister feels that situation today makes such legislation necessary.

"Only 20 percent of the people have a family physician," he pointed out. "Families have also changed significantly. Many have none to rely on and others are spread all over the country. And finally, even though the family makes the decision, the physician has a contract with the patient and has no legal right to withdraw treatment.

"The medical treatment decision bill is supported by the Council of Churches, Michigan State Medical Society, Michigan Nurses Association and every major senior citizens group in the state," he continued. "We're trying to neutralize the Catholic Conference's opposition . . . if they continue to oppose it, it will be much tougher to get through."

Hollister acts determined

Despite the fact that 30 percent or more of the voters in his 57th District are Catholic, Hollister gave no indication he would be deterred. "I think the constituency is ahead of the leadership in many fields," he said with quiet determination. He has also consistently supported the right of free choice in the abortion issue, but has been re-elected two terms since first taking office in 1975. He's considered a "friendly adversary" by those who oppose him. He listens to their position and people trust him even when disagreeing with his philosophy

A native of Kalamazoo, Hollister holds a Master's degree in government and history from Michigan State University. He served on the Ingham County Commission during the last six of nine years he taught in Lansing area high schools. "I taught from 8 a.m. to 4 p.m. and spent from

4 p.m. to 11 p.m. doing commissioner's work," he recalled. "I feel being a legislator is a full-time responsibility, so I no longer teach."

His schedule has remained about as full, however, and he's earned a reputation as one of the most hardworking, conscientious lawmakers in the Capitol. In previous years he's served as chairman of the Mental Health Committee and on the Civil Rights, Public Health, and Social Services and Youth committees. Presently he is a member of the time-consuming and powerful Appropriations Committee but continues his interest in the former fields by serving on subcommittees of Mental Health, Social Services, Public Health, State Police and Computers.

Centers on health

Always interested in human services, Hollister's concerns center on health issues. He can tick off details of these activities without missing a beat. He chairs the Special Committee on Children's Services as well as the Special Joint Committee on Aging and contends, "We should do more to build bridges between the younger and older people."

The community task force Hollister created, "Death and Dying," is now in two parts, having added "The Hospice Concept." "We're trying to come up with a bill for hospices across the state . . . another alternative to institutional care," he said. He is also interested in setting up "Respite Care" programs where elderly people could spend short periods while families caring for them are on vacation.

It was Hollister who cosponsored the bill to reorganize Blue Cross-Blue Shield (Substitute H.B. 4555) which reduces the number of board members from 47 to 31 and makes other sweeping changes. In addition to restructuring BCBSM, the bill contains three health care goals — the first time they've been stated in law:

- **Cost Goal.** The total corporation payment per member for each provider class cannot be higher than the compound rate of inflation and real economic growth in any given year.
- **Access goal.** There will be an appropriate number of providers throughout the state to assure the availability of certificate-covered services to each subscriber.
- **Quality goal.** Providers will meet and abide by reasonable standards of health care quality.

"The health industry argued that regulation is costly and inefficient," he said. "So we said to continue as you are for two years and submit plans qualifiable, measurable and achievable."

If otherwise, the state commissioner could rule they did not meet the goals and order a new plan to be drawn up. If his plan is appealed by the corporation, a three-member appeal group (with a representative from the State Health Coordinating Council, the Commission on Aging and the State Health Advisory Council) could make a choice or combine several plans.

Meanwhile the State Insurance Commissioner would continue to regulate subscriber rates.

Under the proposed law, BCBSM would be allowed a reserve of seven to 13 percent, compared to the higher percentage they requested. "Right now the law is fuzzy on how much reserve they are allowed," Hollister said.

BCBSM bill support

"We're getting support for this bill, except from BCBSM management," he continued. "Labor and provider groups appear to be supporting it."

In the area of nursing homes, the energetic activist is not pleased with the way the Nursing Home Reform Act has been put into effect following passage more than a year ago. "The Department of Public Health was not enthusiastic about it . . . they dragged their feet all the way," he said. "They said they didn't have enough money, but we appropriated about $500,000 in this year's budget for it and all they have to do is ask for more.

"It will take constant vigilance and pressure to see anything is done," he says.

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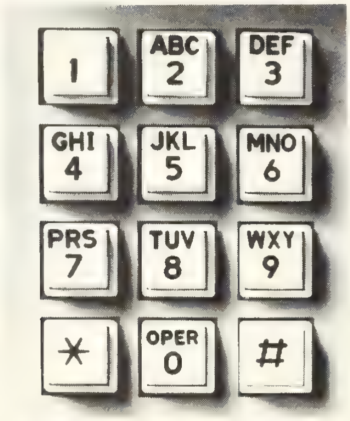

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What county societies are up to these days

Kent County Medical Society

In this issue, MSMS begins a series of occasional articles that highlight the activities of representative county medical societies. They will describe professional and service programs — and include a dash of history as well.

By R. Jack Chase, MD, President
Kent Co. Medical Society

The Kent County Medical Society was founded November 14, 1902 with 43 members. Now it numbers 651. Over the years its members have been traditionally active in the community as well as in the practice of medicine.

Sensing the need for physician availability, the Society was one of the first in the country to establish an Emergency Medical Call Service in December, 1948.

Through its Emergency Medical Services Committee and many actively interested physicians the Society has been in the forefront in the development of excellent emergency medical service, and in CPR training for physicians and other medical personnel. Physicians from the Society have helped to improve emergency medical care nationally.

Community service

The medical exhibits at the Grand Rapids Public Museum were developed through close cooperation with the Society nearly ten years ago. These include The Wonder of Life Display, a Gaslight Village Physician's office, a transparant anatomical manikin, and an exhibit of joint prostheses. Presently, plans are underway to expand the medical exhibits. The Grand Rapids Public Museum and the Kent County Medical Society will continue to be actively involved in these plans.

For several years the Society has cooperated with the West Michigan Shores Council of the Boy Scouts of America, providing lectures, field trips and visits to local and regional medical facilities for Explorer Scouts interested in medical careers.

Volunteer physicians on the Community Health Services Committee of KCMS have, for many years, given physical examinations to needy children attending local summer camps. Fall clinics for school athletic physicians and trainers have been sponsored by the Society.

The members of our Legislative Committee meet with area state legislators monthly to discuss matters of importance. These meetings prove helpful for the exchange of ideas and to maintain communication with legislators.

For the past three years the KCMS in cooperation with a local TV station and the MSMS has produced a monthly panel discussion program, "Ask The Doctor." This has been a popular program, and hopefully will continue to be aired.

An open liaison with the regional Health Systems Agency is maintained by regular meetings with its Executive Director and members of his staff, as well as local physician HSA members and the President, President-Elect and Past President of KCMS. These meetings have been helpful to both parties, especially in establishing the Western Michigan Physicians Advisory Council to the HSA.

This year an ad hoc committee of the Society has investigated the feasibility of an IPA type of HMO for Kent County and reported back to the Society. The Society feels that this type of HMO should be evaluated by a formal feasibility study. The ad hoc committee has been disbanded and further investigatory studies are being carried on outside the KCMS.

The Society has justly been proud of excellent inter-physician and inter-hospital relationships and cooperation. This has led to many shared, well-filled hospital residency programs. Affiliation with the three state medical schools and close cooperation with Grand Rapids Area Medical Education Center contribute to the high level of medical care provided.

Doctor Chase

Medical Foundation

An important and favorite endeavor of the Society is the Kent Medical Foundation, established and funded by the KCMS in 1961 and incorporated in 1966. The Foundation was established solely for charitable, scientific and educational purposes. It has provided tuition grants to 372 deserving students pursuing careers in medicine or allied health fields at the four local colleges and three local schools of nursing.

In addition, the Foundation has issued 146 loans to 79 medical students who need financial help with their education. To date a total of $294,144.89 has been made available by the Foundation.

Though the Foundation continues to receive most of its charitable donations from physicians, the KCMS Auxiliary contributes heavily, especially through the Christmas Card project. In recent years members of the Community interested in the Foundation have also contributed. As planned, it is the community that derives the greatest benefit from the Foundation's efforts, since many (or most) of the recipients of aid return to the Kent County area as practicing physicians and other health professionals.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

William T. Allen, MD IM/PUD
5305 E. Huron River Dr.
Ypsilanti, 48197

Gholam H. Amini, MD AN
3046 Monikon Ct. #602
Flint, 48504

John R. Ammon, MD AN
111 Merriweather
Grosse Pte. Farms, 48236

Andrew P. Andonopoulos, MD IM/RHU
925 La Praire #215
Ferndale, 49220

Regine A. Aronow, MD PD
3901 Beaubien Blvd.
Detroit, 48201

Mohammad I. Azimi, MD OBG
113 N. Washington
Ypsilanti, 48197

Donald P. Cento, MD PTH
2720 Bridle Rd.
Bloomfield Hills, 48013

Ahmed Chaballout, MD GS
29201 Tiffany Dr., W.
Southfield, 48034

Arthur D. Cherkinsky, MD IM/ID
13105 Wales
Huntington Woods, 48070

Bina Chhabra, MD OBG
361 Monroe
Dearborn, 48124

Abelardo B. Contreras, MD N/P
19541 Cherry Hill Ln.
Southfield, 48075

John O. Cox, MD FP
23133 Orchard Lake Rd.
Farmington, 48024

Alan R. Crain, MD ORS
16400 North Park Dr. #1218
Southfield, 48075

Eliezer R. de Leon, MD IM
416 Tobin Dr. #311
nkster, 48141

Roberto O. Denis, MD OBG
2841 Monroe #4
Dearborn, 48124

Robert R. Di Loreto, MD U
245 Stephens Rd.
Grosse Pte. Farms, 48236

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21 Michigan St., N.E. #615
Grand Rapids, 49503

John L. Ehlert, MD ORS
3284 Thorncrest, S.E.
Grand Rapids, 49506

Denis B. Hart, MD D
121 E. Hoover #2
Ann Arbor, 48104

Allen James, Jr., MD IM
12842 Fenkell
Detroit, 48227

Czeslaw J. Kaczynski, MD FP/P
14700 Riverside Dr.
Detroit, 48227

Omar Kadro, MD GS/CRS
1665 W. 12 Mile Rd.
Berkley, 48072

Satish N. Kamath, MD IM
23100 Cherry Hill
Dearborn, 48124

Young Ho Kim, MD CHP/P
6256 Orchard Lake Rd.
West Bloomfield, 48033

Ajit M. Kittur, MD OBG
24555 Haig
Taylor, 48180

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37822 Calka Dr.
Sterling Heights, 48077

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26657 Woodward Ave.
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Southfield, 48075

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Warren, 48092

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820 N. Pine River
Ithaca, 48847

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Southfield, 48075

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Allen Park, 48101

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1450 Covington
Birmingham, 48010

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Lincoln Park, 48146

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Jackson, 49204

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Rochester, 48063

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Ann Arbor, 48104

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Ford Motor Co.
Dearborn, 48121

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Lake Orion, 48035

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1418 Edward Ave., S.E.
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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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REFER TO PDR

Try one form for all claims to streamline office work

By R. Timothy Hogan, CPBC
Ann Arbor

Health insurance forms are a continual source of difficulty for many practitioners.

Claims preparation ties up staff time which could be used more productively. The forms have a tendency to accumulate until clearing them out becomes a major job. Processing jam-ups produce gripes from patients who want to know what's happened to their claims. In some offices, insurance paperwork is a significant factor in the cost of running the practice.

If these or other insurance problems are common in your office, you should be aware of a recently developed management tool for reducing the insurance hassle to a smooth-running routine. Called "superbill," it's a new type of insurance form which can benefit many small to medium-sized practices, especially those which receive a substantial part of their income in insurance payments.

Superbill combines the insurance claim form with the charge slip commonly used to record services rendered and charges made for each office visit. By combining the preparation of these usually separate documents into one operation, superbill virtually eliminates the time-consuming business of collating records and typing up claim forms at a later date. The office portion of the insurance form is complete by the time the patient leaves.

Superbill can be punched to fit into a pegboard accounting system, or it can function on its own. Though the form is available in various standardized formats, we strongly recommend that superbill be adapted to the needs of the individual practice. Insurance companies want a precise itemization of the services performed, and the form which works well for a pediatric office will not be suitable for an orthopedic or radiological practice.

While the details of superbill will vary with the particular form purchased, here is a generalized account of its design and operation.

What 'superbill' contains

A typical example includes space for summarizing the basic billing information — date, patient's name, charge for the visit, payment received, and balance due.

The largest section of the form lists the procedures most commonly performed in the practice, together with the procedural code numbers and spaces for writing in the fee for each service. The code numbers define each procedure for the insurance company computers, and are generally taken from the AMA's five-digit Current Procedural Terminology, though in some states it is advisable to use local codes. Space is usually provided for indicating other less frequently performed services.

Other commonly included features are the doctor's name, address, telephone number, and taxpayer identification number, blanks for writing in the name of the patient's insurance carrier and his policy number, space for the patient's signature authorizing assignment of benefits to the doctor, and space for the patient to authorize release of his medical data to the insurance company.

The section for diagnosis or symptoms is completed by inserting the appropriate International Classification of Diseases (ICDA) code numbers.

How 'superbill' works

The form typically is printed in triplicate — one copy for the office files, one for the patient, and one for the insurance company.

When the patient arrives for his appointment, the receptionist fills in the date and patient's name, enters the current balance, and hands the superbill to the patient.

The patient takes the form with him into the examining room. When the visit is over, the doctor simply marks the procedures performed, and enters the diagnosis using the ICDA code numbers (the insurance carrier will understand them but the patient won't).

When the patient returns the superbill to the receptionist on the way out, it is a simple matter to calculate the fee for the visit, accept payment, enter the new balance, and give the extra copies to the patient.

If the patient is going to file the claim, s/he attaches a duplicate to the company's claim form and mails it in.

If the office is going to file, the patient signs to authorize release of the information. The receptionist retains one of the duplicate copies, attaches it to a standard claim form, and sends it to the carrier.

The entire process is simple, quick, and achieves the following:

1. The claim form is largely completed when the patient leaves the office, regardless of whether the patient or the office does the filing.

2. The patient has an up-to-date, itemized statement of the account.

Superbill is gaining acceptance with insurance carriers in many states, and is available from various suppliers of medical business forms.

Mr. Hogan is management consultant with Professional Management, Ann Arbor, and Black and Skaggs Associates, Battle Creek.

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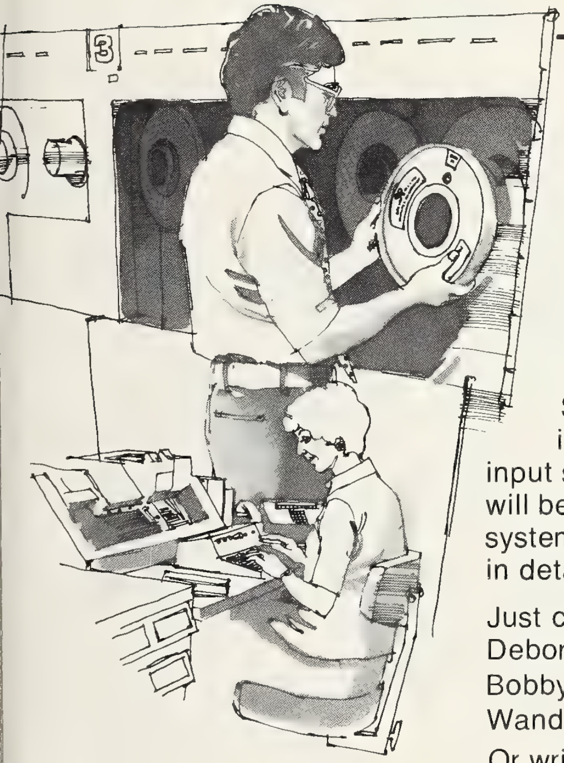

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News

Doctor Brown

Doctor Jones

Doctor Tanay

By Katie Brewbaker
MSMS staff

Emanuel Tanay, MD, WSU clinical professor of psychiatry, has been elected vice president of the American Academy of Psychiatry and the Law. The academy consists of nearly 900 American and Canadian forensic psychiatrists.

The American Society of Anesthesiologists elected **Eli M. Brown, MD,** Detroit, president-elect of its 16,000-member organization. Doctor Brown is professor and chairman of the WSU Department of Anesthesiology and chairman of Sinai Hospital's anesthesiology department.

"As Mayor of the City of St. Ignace, I proclaim Friday, October 12 **Doctor Herman E. Hamel** Day." An official day was set aside so the grateful citizens of this Upper Peninsula community could express their thanks to their friend and "doc" who retired after 32 years of practice.

Alfred B. Swanson, MD, Grand Rapids, has traveled the world during 1979 lecturing on hand surgery. Doctor Swanson's speaking schedule has taken him to Jerusalem, Cairo, Puerto Rico, Sao Paulo (Brazil), and East Grinstead-Sussex (England).

In response to a request from the AMA for nominees to its newly established ad hoc Committee on Women Physicians in Organized Medicine, MSMS is proud to submit the names of **Marjorie Peebles Meyers, MD,** and **Susan A. Adelman, MD,** both of Detroit. From among the nominees submitted by all state medical societies, the AMA will select five physicians to serve on this ad hoc committee.

The MSMS representative to the State of Michigan Medical Care Advisory Council is **Richard H. Gascoigne, MD,** Adrian, with **William H. Harrison, MD,** Lansing, serving as alternate.

President-elect of the Central Association of Obstetricians and Gynecologists is **David G. Anderson, MD,** of Ann Arbor. Doctor Anderson is associate professor of obstetrics and gynecology and associate director of gynecology/oncology at the University of Michigan Medical Center.

John A. Gronvall, MD, dean of the University of Michigan Medical School, has been elected to a five-year term to the National Academy of Sciences' Institute of Medicine. The Institute is charged with the responsibility of studying "problems associated with the delivery of adequate health services to all sectors of society, a goal that is increasingly viewed as a basic human right."

The University of Michigan Regents have appointed **Peter A. Ward, MD,** professor and chairman of the department of pathology. Doctor Ward succeeds **A. James French, MD,** who is stepping down from the chairmanship in June, 1980, after serving 24 years.

Escanaba welcomed a delegation of five high-ranking medical personnel from the People's Republic of China when the doctors visited the staff of the Upper Peninsula Medical Education Program as part of its United States itinerary. Although much curiosity was expressed about the prevalent use of acupuncture in China, UPMEP program director **Paul Werner, MD,** admits it will be a long time before it's practiced in Escanaba, conceding "I first have to learn Chinese before I can read the book!"

Samuel Gershon, MD, New York, has been named director of the Lafayette Clinic in Detroit and chairman of the department of psychiatry at Wayne State University. Doctor Gershon has served as professor of psychiatry at the New York University Medical School where he was in charge of neuropsycho-pharmacology research.

Eric D. Austad, MD, clinical instructor of the U-M Medical Center section of plastic surgery, won first prize in the Junior Clinical category of a scholarship essay contest sponsored by the Educational Foundation of the American Society of Plastic and Reconstructive Surgeons. The Ann Arbor surgeon co-authored an essay on "A Self-Inflating Implant for Donor Tissue Augmentation."

"Maurice likes to prick the bubble of pomposity." That's the way Leanor described her husband, the director of the Michigan Department of Public Health, **Maurice S. Reizen, MD,** when he was the subject selected by the Lansing *State Journal* for its Monday Profile feature. An apt description of the man who in spite of the demands of his job is known in Lansing for his smiling face, sense of humor and remarkable ability to not take himself too seriously.

William Jones, MD, Allen Park, is recipient of the 1979 Martin Wagner Memorial Award of the National Kidney Foundation, the highest honor the foundation gives to one of its volunteers. Doctor Jones was a founder of the Kidney Foundation of Michigan, one of the foundation's oldest and largest affiliates.

"I have great moments to remember. Now it's time to move on," is how **Doctor Richmond Smith, Jr.** puts it as he retires as Henry Ford Hospital's longtime chairman of the Department of Internal Medicine. A graduate of Yale University School of Medicine, Doctor Smith plans to return to his native New England where, in addition to practicing medicine in Maine, he will focus his energies on environmental issues.

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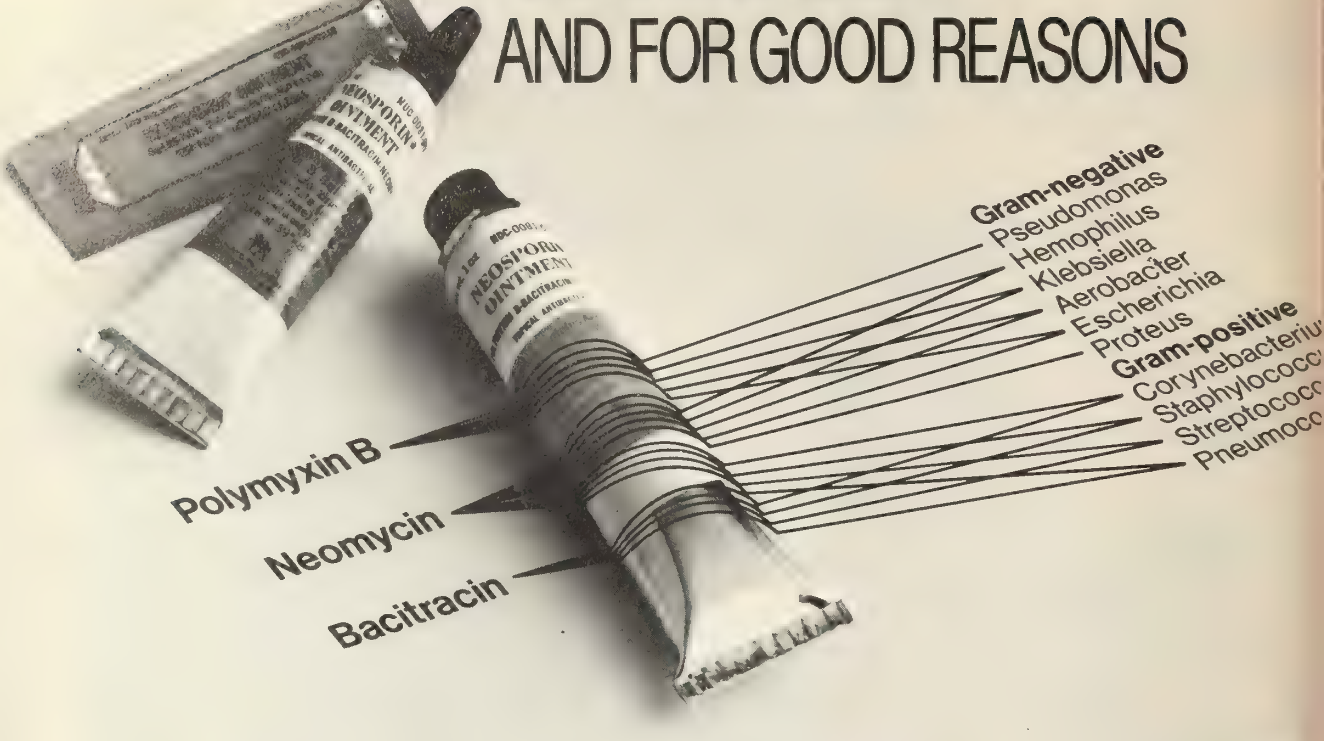

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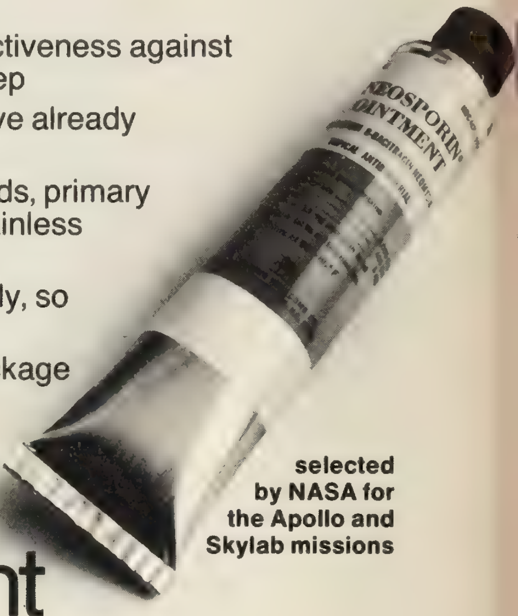

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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MATERNAL HEALTH DESK REFERENCE CARD NO. 23

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

NEONATAL HYPERBILIRUBINEMIA

Jaundice (hyperbilirubinemia) is a frequent sign evaluated and sometimes treated in newborn infants. Although usually benign, jaundice may be caused by serious, life-threatening disease. Regardless of cause, levels of indirect bilirubin may rise to levels toxic to the central nervous system.

Before initiating any treatment, consider: (a) the cause of the jaundice, and (b) the level and expected course of the jaundice.

With *early infant discharge*, a potential for unrecognized pathologic jaundice exists. It is recommended that infants who will be discharged early be evaluated for elevated hematocrit, hematomas, and ABO and/or Rh group incompatibility before release. Cord blood should be kept and parents instructed to seek aid should jaundice occur.

I. Physiologic jaundice — due to immaturities in bilirubin metabolic pathway. Pathologic causes of jaundice may fall within these limits!

Bilirubin (indirect) levels versus age: (Term infant)

Age:	Cord	24°	48°	3-5 days	14 days
Upper limits (mg%):	3	6	7.5	12	2

In prematures, levels are generally higher — a peak level in the premature infant greater than 15 should be considered pathologic.

II. Pathologic jaundice

A. Bilirubin may be either conjugated (direct) or unconjugated (indirect). Only "indirect" type is detailed here.

B. Pattern may be abnormal by being:

1. early: clinically evident in less than 24 hours.
2. pronounced: peak level exceeding maximum allowable for physiologic jaundice at that age.
3. prolonged: persisting beyond 7 days in term and 10 days in preterm infants.

C. Causes:

1. Hemolysis (over-production of bilirubin due to RBC breakdown)
   a. Usually associated with *early* or pronounced hyperbilirubinemia
   b. Most often due to incompatibility in ABO (most common) or Rh (2nd most common) blood groups. (See work-up for differentiation)
   c. May have associated anemia and/or reticulocytosis

Age:	Cord to 5 days	14 days
Hbg lower limit:	14 gm%	12.5 gm%
Reticulocyte upper limit:	7 %	2 %

   d. Some forms of incompatibility, especially Rh, may severely affect the fetus in utero. Presence of antibodies in mother requires prenatal evaluation and possibly immediate exchange at birth.

2. Other over-production
(Usually associated with "pronounced" hyperbilirubinemia)
   a. Bruising (prematures, breech)
   b. Enclosed blood (cephalhematomas)
   c. Polycythemia (SGA, infant of diabetic mother, unattended delivery, delayed cord clamping)

d. Exaggerated enterohepatic circulation (Ileus or GI obstruction)

3. Impaired excretion (usually associated with pronounced or prolonged hyperbilirubinemia)

a. Infection (Neonatal sepsis, congenital non-bacterial infection)
Consider *sepsis* in any newborn with gastrointestinal disturbances, thermoregulation difficulties, respiratory distress, or a "not looking well" appearance — with or without jaundice.

b. Drugs and inhibitors of conjugation: *Drugs* given to mother and/or baby should be evaluated for their effects upon bilirubin transport and/or metabolism. *Breastfeeding* is occasionally a cause for prolonged jaundice.

c. Metabolic diseases associated with jaundice (usually *prolonged*) include:

1) Congenital hypothyroidism

2) Galactosemia

III. Work-up

A. History: Especially previous siblings, familial blood dyscrasias, prenatal and perinatal events. Document on chart.

B. Physical: Especially general condition, pallor, distribution of jaundice, petechiae, hepato-splenomegaly, edema or ascites. Document on chart.

C. Laboratory:

1. Bilirubin:	Direct and indirect
2. Hematologic:	Hct and/or Hbg Smear: RBC morphology, platelets Reticulocytes WBC and differential
3. Blood Bank:	Type, Rh: Mother and Infant Antibody screen — mother Coombs — infant ABO test: infant (if ABO set-up is present and Coombs negative)
4. Urinalysis:	Routine (? UTI) Reducing substances (Clinitest):
5. Consider:	Septic work-up: i.e. blood culture, L.P., suprapubic bladder tap Total protein (albumin) T^4

D. Treatment:

Treat underlying cause and provide careful general supportive care — especially with respect to fluids and feeding.

Treatment of elevated indirect bilirubin

1. Exchange transfusion:

a. Indicated when the level of bilirubin attained is associated with a high probability of C.N.S. toxicity, or when it is highly probable that such a level will be reached.

b. Indicated with signs of kernicterus.

c. Exact levels of bilirubin requiring exchange vary with the clinical circumstances.

d. The following increase the toxicity of a given level of bilirubin: prematurity, previous hypoxia (asphyxia), metabolic disturbances, hypoalbuminemia, certain drugs.

e. Exchange in hemolytic disease: (consultation recommended)

1) For Anemia: Hct less than 45% or Hbg less than 14 gm%

2) Rising bilirubin: Greater than 0.5 mg% per hr. (Rh) or greater than 1.0 mg%/hr (ABO)

3) Serum indirect bilirubin:
exceeds 15 mg% (preterm)
20 mg% (term)

4) Saturation of binding sites: HBABA binding or other tests, if available, may be considered in determining potential toxicity.

f. Exchange without hemolytic disease: Evaluate carefully or obtain consultation if:

1) Indirect bilirubin greater than 18 mg% in well premature

2) Indirect bilirubin greater than 15 mg% in premature with hypoxemia, acidemia, no previous exchange

3) Indirect bilirubin greater than 20 mg% for more than 24 hours in well term infant

g. Exchange transfusion should be done by person familiar with the procedure and in a setting with full resuscitation and monitoring capability.

2. Phototherapy: The visible blue part of the light spectrum destroys bilirubin.

NOTE: The use of this modality of therapy is not accepted nor used by all pediatricians.

a. If light therapy is contemplated full *diagnostic work-up* is indicated and results should be documented in the record.

b. Phototherapy may be used while setting up for an exchange or in conjunction with and following an exchange.

c. Phototherapy is used to attempt to prevent indirect bilirubin from reaching or exceeding exchange levels.

d. The same factors regarding bilirubin toxicity outlined above should be used when considering use of phototherapy.

e. In general, phototherapy can be considered when the serum indirect bilirubin is greater than 10 mg% and the level is expected to rise to higher potentially toxic levels. Lights should be discontinued when the level falls below 10 mg%.

f. When under phototherapy:

1) Clinical jaundice becomes useless for estimating levels; therefore serial bilirubins must be done once or twice daily (more often PRN).

2) Concentrated light may have eye toxicity; therefore the eyes should be covered.

3) Fluid needs increase due to increased insensible losses from skin and stools (stools may become loose).

4) Hemolysis will continue, therefore Hct's must be followed serially until spontaneous rise is documented, often at several weeks of age. Anemia may require packed cell transfusion.

5) Some babies develop a skin rash.

6) Time under treatment should be documented in the record.

g. When discontinuing phototherapy, follow-up bilirubin levels must be done to detect rebound.

3. Other forms of therapy:

Agar binds bilirubin in the gut and therefore decreases enterohepatic circulation. Data is incomplete and no recommendation for this form of therapy is made.

Prophylaxis — no form of prophylaxis for hyperbilirubinemia (e.g. phenobarbital) is recommended at present.

NB: Some nurseries restrict the use of phototherapy to those cases in which a future exchange might be more hazardous than usual. Others use phototherapy in cases approaching or which are expected to approach exchange levels. It is strongly recommended that the record document the diagnostic work-up and therapeutic rationale used.

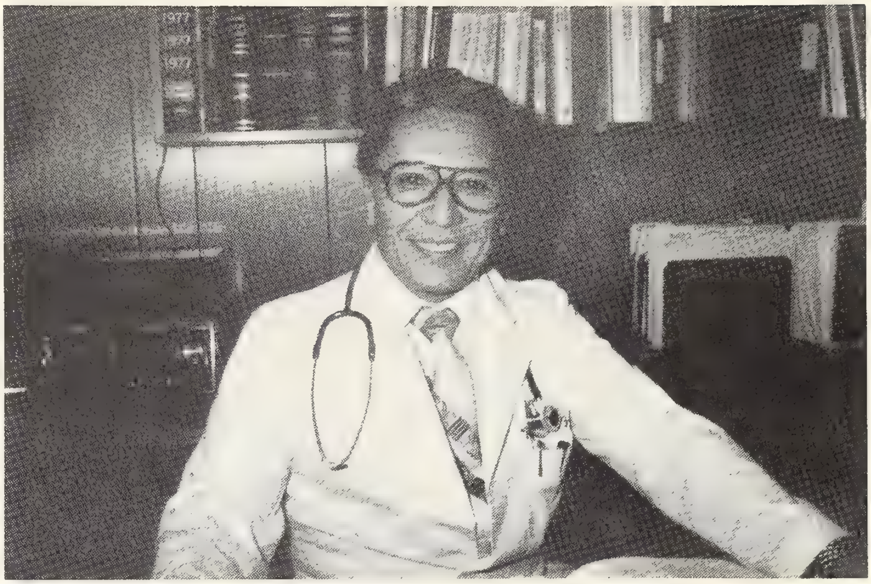
This reference card prepared by John V. Hartline, MD with assistance from Ronald L. Poland, MD

How one FMG has adjusted to life and medical practice in the U.S.

By Hugo R. Saenz, MD
Lansing

When you come to America as a graduate from a foreign medical school, you bring a little piece of your homeland with you. It remains with you forever, even though you may succeed in the difficult transition process from an almost totally different culture to that of becoming an American.

The first obstacle is language. You have to be fluent enough to communicate with your patients and fellow physicians as well as the butcher, the baker and the pharmaceutical detail man. The fact that you may have an accent really doesn't matter as long as it is not too thick or difficult to understand. Whereas a Peruvian, for example, would look down his nose at a visitor from the United States speaking Spanish with a heavy American accent, the Americans themselves are very tolerant of foreign accents.



Doctor Saenz in his Lansing office.

Idioms, too

The foreign medical graduate also needs to speak in idiomatic English. I learned much of my idiomatic English by reading American comic books when I first arrived to this country in the middle 1950s.

Another obstacle is to communicate with your fellow physicians in the medical terminology they use every day. For instance, after a pelvic examination of a patient the diagnosis of bilateral salpingitis and oophoritis is perfectly correct. However, you are better off sticking to current medical terminology and call it acute PID. If you don't, your colleagues will regard you as "that new foreign doctor in town."

I learned these basic words of wisdom for foreign medical graduates during my transition from chief of the Department of Sera and Vaccines at the National Institute of Health in Lima, Peru to family physician in Lansing, Michigan, U.S.A.

My medical education was obtained at the University of San Marcos in Lima, which is the oldest University in the Western Hemisphere. I received my medical degree in 1951 after completing a one-year rotating internship at the University Hospitals in Lima. During my second year in medical school, I was named an assistant professor of microbiology and was teaching my classmates parasitology and bacteriology. After graduation I became chief of the Department of Sera and Vaccines of the National Institute of Health.

U.S. invitation

While in this position, I met a man who was instrumental in convincing me to come to the United States. He is William Gebhard from the Virology Department of the Michigan Department of Public Health. Bill was among a team of scientists from the World Health Organization who came to Peru to train the Peruvians in the use of the lyophilized smallpox vaccine.

Some time later, on the recommendation of my new American friend, Bill Gebhard, I was granted a fellowship in 1953 by the Pan American Sanitary Bureau of the World Health Organization. The pur-

Please see related articles in special section, pages 667-670.

Dr. Saenz is the president-elect of the Ingham County Medical Society; immediate past president of the Capital Area Chapter of the Michigan Academy of Family Physicians; and chairman of the Department of Family Practice at Ingham Medical Center, Lansing.

SAENZ/*continued*

pose of the fellowship was to study the preparation of vaccines, especially for those diseases prevalent in Peru such as rabies, pertussis, diphtheria, smallpox, bubonic plague and typhoid fever.

FBI arrest

I arrived in the Miami airport carrying a large thermos bottle containing live viruses which I had brought from Peru and which I wanted to be tested in this country. Upon my arrival, I was promptly arrested by the FBI. Ironically, I was not detained for the lethal contents of my thermos bottle. The FBI never asked me about the bottle. I was arrested because the FBI had received a tip that a Communist agent was among the five Latin Americans on the plane landing in Miami. After my release, I continued on my journey to Lansing and the Michigan Department of Public Health. The first thing that Bill Gebhard did upon my arrival was to destroy my thermos of live viruses.

During my eight months at the Michigan Department of Public Health, I went through an accelerated course in the preparation and testing of vaccines. In that time I also met and married my wife, Laura, who was a microbiologist in the department. At the end of the fellowship, my wife and I returned to Peru to fulfill my contract with the Peruvian Government at the National Institute of Health. In 1955 we left Peru and came back to Lansing where I was accepted as an intern at St. Lawrence Hospital.

At the time of my internship, it was necessary for all foreign medical graduates to take an Oral Screening Test for Foreign Physicians. This was conducted at Ann Arbor before a panel of 12 professors. I took the exam and passed all parts of it except for microbiology and public health, my forte in Peru. Fortunately a law was passed at the same time, eliminating the need for an intern to pass this exam. Upon completing my internship in 1956, I took the screening examination again with the same results.

It was then that I realized my difficulty was not in knowledge but in my attitude and credibility in the eyes of the panel. I had projected an air of overconfidence and they could not believe that this young Peruvian had held a high position in the government in the field of microbiology. Later, after a year of a basic science course at the University of Michigan, I passed all required examinations with no difficulty. Of course, I took the exams with a different attitude more acceptable to American professors.

Another problem was understanding the monetary system and relating it to the fees I should charge my patients. In Peru the Sol was worth about five cents at that time, but it could buy a great deal in my homeland. When I thought of dollars in terms of Soles, I was in trouble until I changed my way of evaluating the dollars for what they could really buy in the United States.

Becoming American

I have touched upon but a few of the problems encountered by a foreign medical graduate in becoming established in America. Our cultural background may be different, yet if we learn to think and act as Americans, we eventually become one even though we always carry a piece of our country with us.

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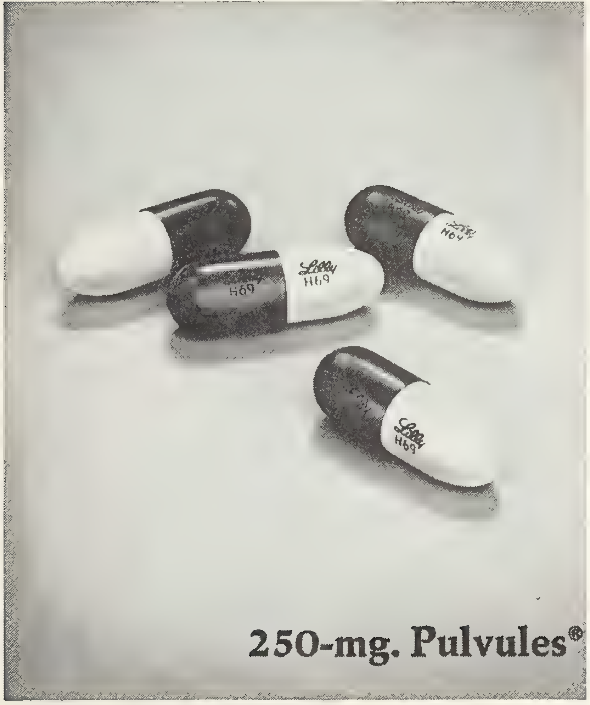

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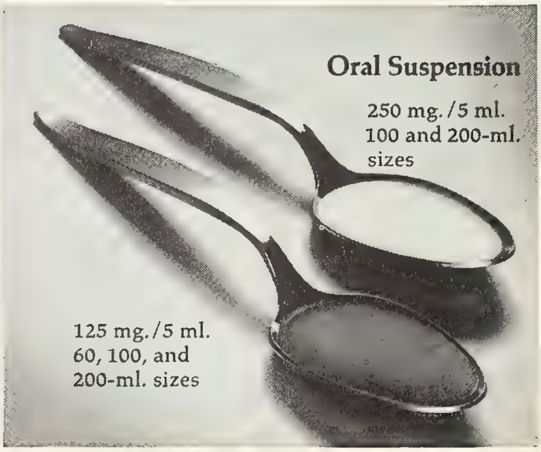

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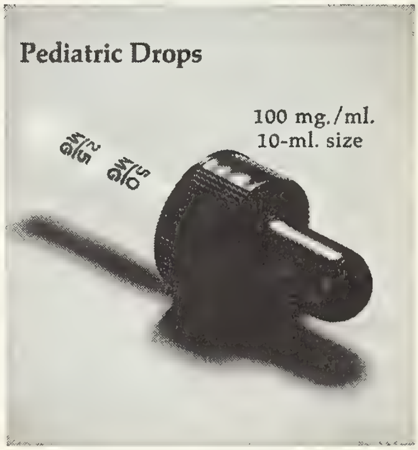

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— *Alan E. Beer, MD,* U-M

VIRAL INFECTIONS
— *John L. Sever, MD,* Maryland

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March 6

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— *Gertie F. Marx, MD,* New York

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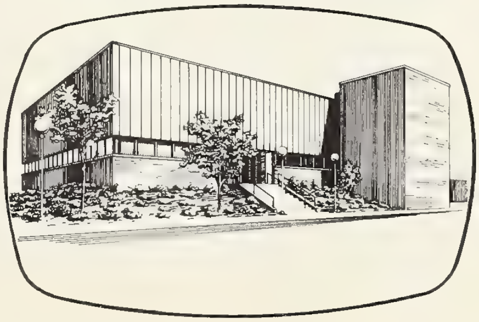

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Category I courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.*

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: **Jan. 9, 16, 23 & 30, 1980, Liaison Psychiatry. Location:** Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., Detroit 48235. **Approved for:** 6 hours of Category I Credit.

Date: Jan. 16, 1980, Hypertension. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236. (313/343-4000). **Approved for:** 8 hours of Category I credit.

Date: Feb. 3-8, 1980, Midwinter Family Practice Update. Location: Boyne Highlands, Harbor Springs. **Sponsor:** U-M Office of Continuing Education. **For:** All interested physicians. **Cost:** $200. **Contact: Towsley Center for CME, 313/764-2287. Approved for:** 20 hours of Category I Credit.

Date: Feb. 9, 1980, New Approaches to Common Problems in Clinical Microbiology. Location: Henry Ford Hospital, Detroit. **Sponsor:** The Michigan Society of Pathologists. **For:** All interested physicians. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, 48235. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 9-16, 1980, Infectious Diseases Today. Location: Aboard tss Festivale in the Caribbean. **Sponsor:** Wayne State University School of Medicine, Div. of CME. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 1206 Scott Hall, Detroit, MI 48201 (313) 577-1180. **Approved for:** 36 hours of Category I Credit.

Date: Feb. 13, 20, 27 and March 5, 12 & 19, 1980, Child Development. Location: Auditorium, Mount Carmel Mercy Hospital, Detroit. **Sponsor:** Mt. Carmel Mercy Hospital, Sinai Hospital of Detroit and the Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** $25. **Contact:** Daniel Schwartz, Dept. of Psychiatry, Sinai Hospital of Detroit, 6767 West Outer Dr., 48235. **Approved for:** 9 hours of Category I Credit.

Date: Feb. 18-22, 1980, Emergency Medicine. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Education. **For:** Emergency physicians, Family physicians, Internists, EMT's. **Cost:** $275. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 36½ hours of Category I Credit.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital
Oakwood Hospital, Dearborn
Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

Date: Feb. 22-24, 1980, Mid-Winter Meeting. Location: Hospitality Inn, Lansing. **Sponsor:** Michigan Academy of Family Physicians. **For:** Family physicians. **Cost:** $85. **Contact:** Michigan Academy of Family Physicians, 416 North Homer, Suite #107, Lansing, MI 48912. **Approved for:** 14 hours of Category I Credit.

Date: March 19-21, 1980, Advances in Pediatrics. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** $190. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 19, 1980, Infectious Diseases in Obstetrics and Gynecology. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: March 26-28, 1980, Urology Conference. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** $175. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 21 hours of Category I Credit.

Date: March 27-April 2, 1980, MAFP and SCAFP "Ails of Summer" Meeting. Location: Kiawah Island, Charleston, SC. **Sponsor:** Michigan Academy of Family Physicians and South Carolina Academy of Family Physicians. **For:** Family physicians. **Cost:** $100. **Contact:** Michigan Academy of Family Physicians, 416 North Homer, Suite #107, Lansing, MI 48912. **Approved for:** 25 hours of Category I Credit.

Date: March 29, 1980, Gastroenterology for the Family Physician. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Contact:** Towsley Center for CME. 313/764-2287. **Approved for:** 7 hours of Category I Credit.

Date: May 2-3, 1980, Nuclear Radiology Workshop. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **For:** All interested physicians. **Cost:** $150. **Contact:** Floyd C. Pennington, Director, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109. **Approved for:** 16 hours of Category I Credit.

Date: May 21, 1980, Medical Therapy in Family Practice. Location: Saint John Hospital. **Sponsor:** CME Committee of Saint John Hospital. **For:** All interested physicians. **Cost:** $90. **Contact:** Ms. Linda Radu, Secretary, Continuing Medical Education, Department of Health Education, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313/343-4000). **Approved for:** 8 hours of Category I Credit.

Date: July 25-27, 1980, EKG Interpretation and Arrhythmia Management. Location: Grand Hotel, Mackinac Island. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** $215.00. **Contact:** International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, CO 80112 (800) 525-8646 Toll Free or (313) 773-1144. **Approved for:** 15 hours of Category I Credit.

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Jan. 12 — 21st AMA Conference on the Medical Aspects of Sports, San Antonio, contact: Department of Environmental, Public and Occupational Health, AMA, 535 N. Dearborn, Chicago, IL. 60610.

Jan. 12-15 — AMA Winter Scientific Meeting, San Antonio, contact: Department of Scientific Assembly, AMA, 535 N. Dearborn, Chicago, IL 60610.

Jan. 23 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 25 — MSMS/Intrav South American Adventure, contact: Marcelyn Ireland, MSMS headquarters.

Feb. 2-3 — Mid-Winter Seminar, State of Michigan Branch, American Association of Medical Assistants, Weber's Inn at Ann Arbor, contact: Frances Drawe, 2171 Medford, Apt. 33, Ann Arbor, 48104.

Feb. 21-24 — 8th Annual AMA National Leadership Conference, Downtown Marriott Hotel, Chicago, contact: AMA, 535 N. Dearborn, Chicago, IL 60610.

March 5 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 5-6 — MSMS Michigan Conference on Maternal and Perinatal Health, Hyatt Regency, Dearborn, contact: Katie Brewbaker, MSMS headquarters.

March 9 — Board Meeting, State of Michigan Branch, American Association of Medical Assistants, MSMS headquarters, contact Caroline Rich, MSMS headquarters.

April 17 — AMA 33rd National Conference on Rural Health, Sheraton-Boston, contact: Barbara Chapman 312/751-6604 or Gary Schwartz 312/751-6431.

April 17-19 — Annual Convention and House of Delegates, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn at Plymouth, contact: Margaret Broadwell, 16686 East Eight Mile Rd., Detroit, 48205.

April 25-27 — 1980 MSMS House of Delegates, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

July 10-13 — MSMS Council, Holiday Inn, Marquette, contact: Warren Tryloff, MSMS headquarters.

Sept. 10 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 22 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Dec. 3 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

Jan. 4 — Michigan Health Officers Association Board of Directors Meeting, at Michigan Department of Public Health, Lansing, contact: Evelyn Richey, Office of Local Health Services, Michigan Department of Public Health, 517-373-9680.

Jan. 8 — "Otitis Media and Pneumonia," sponsored by the Detroit Pediatric Society, Detroit Plaza Hotel, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018.

Jan. 9 — Membership Meeting sponsored by Michigan Dermatological Society, Beaumont Hospital, Royal Oak, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

Jan. 12 — "Portraits of the Self: An Illustrated Case Report," sponsored by Michigan Psychoanalytic Society, at MPS headquarters, Southfield, contact; Ronald M. Benson, MD, Michigan Psychoanalytic Society, 16310 W. 12 Mile Rd., Suite 204, Southfield, 48076.

Jan. 16 — "Mediators of Immediate Hypersensitivity — New Information on Release Mechanisms," sponsored by Michigan Allergy Society at Dearborn Inn, Dearborn, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

Jan. 17-18 — Symposium on Diabetes sponsored by U-M Office of CME, at Towsley Center, Ann Arbor, contact: Towsley Center for CME, 313/764-2287.

Jan. 22 — "Suicide and Psychological Problems in Adolescents," sponsored by Detroit Pediatric Society, Detroit Plaza Hotel, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018.

Jan. 23-25 — Ford Hospital Sponsors MSOG, Michigan Society of Obstetricians and Gynecologists, Sugar Loaf, contact: Bruce H. Druckker, MD, Department of Obstetrics & Gynecology, Henry Ford Hospital, Detroit, 48202, (313) 876-2464.

Feb. 5 — "Neonatology for the Practitioner," sponsored by Detroit Pediatric Society, William Beaumont Hospital, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018.

Feb. 7 — "Object-relatedness and the Analysis of Narcissistic and Borderline Psychotic Disorders," sponsored by Michigan Psychoanalytic Society, at MPS headquarters, Southfield, contact: Ronald M. Benson, MD, Michigan Psychoanalytic Society, 16310 W. 12 Mile Rd., Suite 204, Southfield, 48076.

(Continued on page 718)

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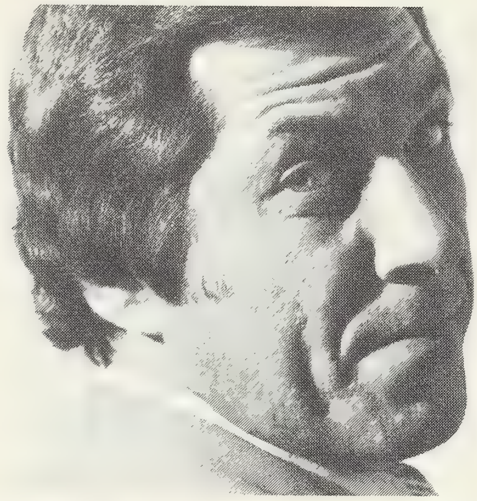

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Form No. 956

Feb. 9 — New Approaches to Common Clinical Microbiology Problems, sponsored by Michigan Society of Pathologists, Henry Ford Hospital, contact: T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, 6071 W. Outer Dr., Detroit, 48202.

Feb. 9-10, March 22-23, April 26-27, May 17-18 — Sexuality Training for Professionals, at Michigan League, Ann Arbor, contact: Michael Brown, 6869 Marshall Rd., Dexter, 48130. 313/426-2334.

Feb. 13 — Membership Meeting sponsored by Michigan Dermatological Society, Henry Ford Hospital, Detroit, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

Feb. 19 — "Counseling Parents of Children with Difficult Temperament, Temper Tantrums, Toilet Training, Etc.," sponsored by Detroit Pediatric Society, Detroit Plaza Hotel, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018.

March 3-4 — Symposium on Diabetes, sponsored by U-M Office of CME, at Hospitality Motor Inn, Grand Rapids, contact: Towsley Center for CME, 313/764-2287.

March 4 — "Atopic Dermatitis and Birth Marks," sponsored by Detroit Pediatric Society, St. John Hospital, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018.

March 5 — Membership Meeting sponsored by Michigan Dermatological Society, University of Michigan, Ann Arbor, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

March 18 — "Infant Nutrition," sponsored by Detroit Pediatric Society, St. Joseph Mercy Hospital, Pontiac, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018.

March 19 — "Coping Styles in Bronchial Asthma Patients," sponsored by Michigan Allergy Society, at Dearborn Inn, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

March 27 — "Consciousness in Contemporary Psychology and Psychotherapy," sponsored by Michigan Psychoanalytic Society, at MPS headquarters, Southfield, contact: Ronald M. Benson, MD, Michigan Psychoanalytic Society, 16310 W. 12 Mile Rd., Suite 204, Southfield, 48076.

***Don't miss the January issue of* Michigan Medicine**

for full details of 1980 Michigan Conference on Maternal and Perinatal Health

March 5-6
Hyatt Regency
Dearborn

May 1-2 — Annual Meeting and Resident Surgeons Day, Michigan Chapter, American College of Surgeons, at Detroit, contact: J. H. McLaughlin, MD, 604 N. Woodward, Birmingham, 48011.

May 2 — Annual Meeting, Michigan Society of Thoracic Surgeons, at Detroit, contact: Rodman E. Taber, MD, Michigan Society of Thoracic Surgeons, 30050 Hoover Rd., Warren, 48093.

May 7 — Executive Committee Meeting, Michigan Allergy Society, at Henry Ford Hospital, Detroit, contact: Benjamin Stone, MD, 1005 Abbott Rd., East Lansing, 48823.

May 10 — Pulmonary Pathology and Transbronchial Biopsy sponsored by Michigan Society of Pathologists, Borgess Hospital, Kalamazoo, contact: T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, 6071 W. Outer Dr., Detroit, 48202.

May 12-13 — Symposium on Diabetes, sponsored by U-M Office of CME, at Holiday Inn, Marquette, contact: Towley Center for CME, 313/764-2287.

June 7-8 — Spring Symposium, Michigan Otolaryngological Society, at Bay Valley Inn, Bay City, contact: Dieter Wendling, MD, Macomb Ear, Nose and Throat Center, 14 Belleview, Mt. Clemens, 48043.

June 13-15 — Annual Meeting Michigan Dermatological Society, Bay Valley Inn, Bay City, contact: Alejandro Morales, MD, Dept. of Dermatology, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202.

June 13-15 — Annual Meeting, Michigan Chapter, American College of Chest Physicians, at Boyne Highlands, Boyne City, contact: Susan Gibson, American Lung Association of Southeast Michigan, 28 W. Adams, Detroit, 48226, 313/961-1697.

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Deaths

William H. Alexander, MD
Iron Mountain

William H. Alexander, MD, Iron Mountain, died October 5 at the age of 84. He received his MD in 1920 from Harvard Medical School. Until his retirement Doctor Alexander was affiliated with Dickinson County Hospital and the VA Hospital in Iron Mountain.

Albert S. Crawford, MD
Laguna Hills, CA

Albert S. Crawford, MD, Laguna Hills, CA, died October 8. He was 92. Doctor Crawford earned his MD from Cornell University Medical School. He was head of the neurosurgery department at Henry Ford Hospital, Detroit, from 1926 until his retirement in 1952. Doctor Crawford was one of about 60 neurosurgeons in the country when he joined Ford Hospital and is believed to have been the first neurosurgeon in Detroit.

Azat Hogikyan, MD
Southfield

Azat Hogikyan, MD, Southfield, died October 14. He was 60. Doctor Hogikyan earned his MD from the University of Istanbul. He was formerly director of out-patient services in the tuberculosis clinic at the old Hermann Kiefer Hospital. Other posts held by Doctor Hogikyan during his career were chief of pulmonary diseases at Providence Hospital and head of hospital and office training at Wayne State University Medical School.

George F. Peggs, MD
Dearborn

George F. Peggs, MD, Dearborn, died October 21 at the age of 68. He received his MD from Ohio State University Medical School. He was chief of staff and a director of Detroit Memorial Hospital. At the time of his death Doctor Peggs was also affiliated with Dearborn's Oakwood Hospital.

Jerry A. Thornton, MD
Ecorse

Jerry A. Thornton, MD, Ecorse, died October 9. He was 71. Doctor Thornton earned his MD in 1940 from Howard University in Washington. He founded the Ecorse Well Baby Clinic in 1944 and was named Ecorse city physician in 1945. He was on the staffs of Clearwood, Outer Drive and Hutzel hospitals.

In memoriam: Jacques Gottlieb, MD

By Bruce Ambrose, Manager
MSMS Government Relations Department

Jacques S. Gottlieb, MD, 72, world recognized for his research in schizophrenia, founding director of Lafayette Clinic, Detroit, and retired chairman of the Wayne State University Department of Psychiatry, died in his home in Troy, Michigan, October 3.

Born in Trinidad, Colorado, in 1907, and graduated from Harvard University Medical School in 1932, Doctor Gottlieb received honors for his research achievements from national and international scientific groups. He received the Gold Medal Award for pioneer work in psychiatric research from the Society of Biological Psychiatry; an honorary degree of Doctor of Science from Trinity College, Dublin, Ireland; honors from the Asociacion Argentina de Psiquiatria Biologica; and the 1973 Taylor Manor Hospital Psychiatric Award for "outstanding contributions to biological psychiatry and as a tribute to the genius of scientists dedicated to easing emotional and psychiatric suffering."

Among his most cherished honors was the Certificate of Commendation by the Michigan State Medical Society in 1973. Doctor Gottlieb said at the time, "This is important, for it is recognition by one's own daily peers. I am most proud of this award."

Doctor Gottlieb was graduated from Harvard Medical School.

In July, 1955, he assumed the position as Director of the Lafayette Clinic and Professor of Psychiatry at Wayne State University School of Medicine. He was chairman of the Department of Psychiatry from 1961 to 1972. He retired as director of Lafayette Clinic in 1974.

In addition, Doctor Gottlieb was a committee member in several national psychiatric and medical organizations, including membership on The Council and Executive Committee of the Americal Psychiatric Association. Doctor Gottlieb was president of the Michigan Society of Psychiatry and Neurology in 1962-63, and president of the Society of Biological Psychiatry in 1972-73. He was director of the American Board of Psychiatry and Neurology, Inc., from 1959 to 1967, vice-president in 1966, and president in 1967.

While in Lafayette Clinic, Doctor Gottlieb and his colleagues were credited with a major breakthrough in uncovering a biological basis for schizophrenia. The Lafayette scientists isolated and partly identified an enzyme without which the brain may produce symptoms of schizophrenia.

Throughout his career, he published more than 160 scientific articles on the results of his investigative work.

Frank Ochberg, MD, Director of the Department of Mental Health of the State of Michigan said, "Doctor Gottlieb's achievements in schizophrenia research have been noted by scientists from Moscow to Washington to Tokyo. His international reputation was earned over a period spanning two decades. In addition to his scientific pursuits, he was an esteemed educator and hundreds of his students in psychiatry, psychology, neurology, psychiatric nursing, and other mental health disciplines benefitted from his instruction."

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Classified

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

ANESTHESIOLOGIST WANTED for 250 bed acute care hospital in Adrian, Michigan. Pleasant college community, close to Ann Arbor and Toledo. Opening in this four man department due to retirement of one member. Michigan license required. Contact: Richard Gilmartin, MD, Bixby Hospital, Adrian, MI 49221 (517) 263-0711.

OB-GYN required for Michigan Lakeside city of 40,000 people. Terms negotiable. Contact: MSMS, Box 18, 120 W. Saginaw, East Lansing, MI 48823.

INTERNIST AND PEDIATRICIAN wanted for attractive practice in Central Michigan community. Ideal for couple. To join group of internists with subspecialty. Write with C.V. to: MSMS, Box 19, 120 W. Saginaw, East Lansing, MI 48823.

SUBSPECIALTY INTERNISTS — EXCELLENT OPPORTUNITY. PLEASANT ATMOSPHERE. McLaren General Hospital, Flint, Michigan, is currently seeking internists in all subspecialties for teaching faculty positions in Internal Medicine associated with hospital-based private practice. Opportunity provides quarter-time paid teaching salary, excellent private practice setting. Physicians must be ABIM certified and subspecialty certified/eligible. McLaren General Hospital is a 469 bed university-affiliated, excellent acute care hospital with General Surgery, Internal Medicine, Orthopaedic Surgery, Ob-Gyn, and Psychiatry training programs and undergraduate recreational and cultural opportunities. Address inquiries and C.V. to: Michael Giacalone, Jr., MD, Director of Medical Education, McLaren General Hospital, 401 S. Ballenger Hwy., Flint, Michigan 48502. (313) 762-2321.

EXPERIENCED GENERAL SURGEON needed to join two general internists, a gastroenterologist, four family practitioners and a pediatrician in a busy Satellite of the Marshfield Clinic at Ladysmith, Wisconsin. Complete details and personal interview will be arranged for qualified applicants. Send curriculum vitae, bibliography and three references to William M. Toyama, MD, Department of Surgery, Marshfield Clinic, 1000 N. Oak Avenue, Marshfield, Wisconsin 54449.

MEDICAL ONCOLOGY FELLOWSHIP — Currently available for 1 or 2 years at the Edward W. Sparrow Hospital, Lansing, Michigan. Emphasis on clinical training with research opportunities. Prefer applicant who has completed 2 years of Internal Medical Training. Send curriculum vitae to Francis A. Breen, Jr., MD, Director of Medical Oncology, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, Michigan, 48909. A Nondiscriminatory Affirmative Action Employer.

POSITIONS AVAILABLE for psychiatric residents at the PGY-2 and PGY-3 level to augment a 36 position residency program starting as early as January of 1980. Inquiries should be directed to: Clifford C. Kuhn, MD, Director of Basic Residency Program, University of Louisville School of Medicine, Department of Psychiatry and Behavioral Sciences, Health Sciences Center, P.O. Box 35260, Louisville, Kentucky 40232.

MEDICAL DIRECTOR WANTED for Jackson Med Center, Inc. a non-profit clinic. Position includes directing capable medical support staff, monitoring and providing patient care and planning for future expansion of present and future services provided. Ideal opportunity for aggressive physician interested in operating a "no risk" general practice. Internists and/or Family Practitioner preferable. Excellent salary (presently up to $50,000) and fringe benefits. No investment required. Max. 40 hr. work week. Resumes to: Jackson Med Center, Inc., 612 First Street, Jackson, Michigan 49201. Attention: E. Willoughby, MD.

EMERGENCY MEDICINE POSITIONS: available with Emergency Physician Group throughout Michigan, PA, NY, NJ, and Southeastern U.S. including all suburban, rural and metropolitan areas. Fee-for-services with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Please send resume to: NEEMA Emergency Medical, Ste. 400, 399 Market St., Philadelphia, PA 19106 or phone (collect) 215-925-3511.

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DIRECTOR OF OBSTETRICS/GYNECOLOGY — Saginaw Cooperative Hospitals, Inc. is seeking a certified Obstetrician/Gynecologist with subspecialty training, and interest in both undergraduate and graduate training. Undergraduate program is affiliated with Michigan State University, College of Human Medicine. Residency program is accredited for four years of graduate education. Research opportunities available. Salary and fringe benefits are competitive. We are an Equal Opportunity Employer. Interested qualified applicants should contact: Thomas Cinque, MD, Saginaw Cooperative Hospitals, Inc., 1000 Houghton Ave., Saginaw, Michigan 48602, Telephone: (517) 771-6878.

WANTED: Full-time Staff Physician for 350-bed accredited Hospital providing rehabilitation, psychiatric and chronic disease services. General practice or internal medicine training and experience beneficial. Successful candidate must have Michigan License. Excellent salary and fringe benefits. Submit qualifications to: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, MI 48605.

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Statement of ownership, management and circulation of *Michigan Medicine*

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published three times per month, 36 issues, mailed at East Lansing, Michigan, and additional post offices in Ingham County for December 1, 1979.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

3. The publisher is the Michigan State Medical Society. The managing editor is Judith E. Marr, 120 West Saginaw Street, East Lansing, Michigan 48823.

4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

5. The known bondholders, mortgagees and other holders owning or holding one percent or more of total amount of bonds, mortgages, or other securities are: None.

6. A. The total number of copies printed averages 8,977 per issue with a single issue nearest to filing date accounting for 9,163 copies.

   B. Paid Circulation 8,594 subscriptions by mail, these being the active members of the Michigan State Medical Society, and others who receive subscriptions.

   C. Sales to dealers, number none.

   D. Free distribution by mail carrier or other means: 277.

   E. Total number of copies distributed is 8,872.

I certify that the statements made by me above are correct and complete.

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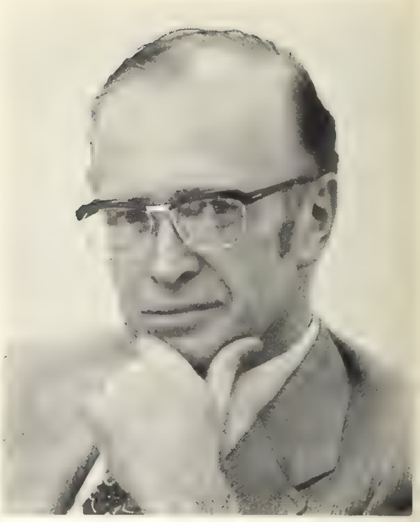
President's page

Physicians can take the lead in treating public's social ills



John R. Ylvisaker, MD
MSMS President-elect

After assimilating all the comments made at the recent MSMS Public Affairs Conference, one ought to perceive a pattern — a thrust for organized medicine to follow. (See special reports on pages 672-676).

Initiatives needed

An MSMS strategy based on the messages of the conference calls for initiatives by physicians: innovative, fresh new movements that will indeed influence the delivery of economical, quality health care in the 1980s.

It must be partly defensive, of course, to avert, in our behalf and in behalf of our patients, serious errors in public policy that will in fact accelerate costs and encroach on quality medical practice.

Congressman Stockman laid it out for us. There are lots of government people who are perfectly willing to take on the problem we ought to take on. There are an equal number of government people — in the Federal Trade Commission, the Food and Drug Administration, the Federal Election Commission — who would prevent us from our own initiatives.

This month MSMS President Ernest P. Griffin, Jr., MD, gives his page to a special guest column by Doctor Ylvisaker. Please see further conference reports on pages 672-678.

A maxim we must keep before us is that if the problem goes to government, it will not be resolved. We in medicine cannot argue that government will make the wrong decisions: We must argue that government makes few *effective* decisions.

Look ahead

Let's try now to foresee the next 18 months in terms of the Michigan State Medical Society.

Entering a new decade is not a mere chronological change. It is cosmetic: It has an effect on the individual and the collective psyche. The 1980s will provide an arena for many, many new ideas in medical care, both through practice and through public policy.

If physicians comprehend the perceptions of the public, and lend their knowledge, their intuition, their expertise, their energies to resolving the problems, we will remain the foremost factor in the delivery of health care.

We must forge new policies that are tuned into the times.

We must enter into the exciting programs such as Walter McClure outlined.

We must reaffirm our commitment to the compassion and to the quality and the patient care that our profession stands for.

Define objectives

We must define our own objectives in new terms, suited to new days.

The finest example that comes to mind is the development of an MSMS "white paper" on cost containment legislation, with eight solid principles on which doctors throughout Michigan can stand as physicians, as citizens, as actors in the scenario. This paper currently is being written by the Task Force on Cost Containment Legislation, chaired by Robert Hamburg, MD, Detroit.

If we continue to do that, and repeat it with each new issue, I promise you . . . not a return to the good old days we remember, but a new decade in which doctors are treating the disease of the populace as well as the diseases of the patients.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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BREAKING NEWS FOR MICHIGAN DOCTORS

Michigan Medicine
Medigram

VOL. 78, NO. 36 DECEMBER 21, 1979

CAPSULES

ELECTED TO THE MSMS Judicial Commission in recent elections are: Edwin R. Guise, MD, Detroit, District One and Adam C. McClay, MD, Traverse City, District Seven. Harold A. Machin, MD, Kalamazoo, was re-elected from District Five. MSMS President Ernest P. Griffin Jr., MD, will appoint a new commissioner soon to fill the vacancy created by the death of John Doran, MD, District One.

EDWARD J. KLOPP JR., MD, of Battle Creek has been named to the five-member Certificate of Need board by Governor Milliken. The board will serve as the appeal body for CON applications with authority to grant the certificate or to modify the bed reduction order for a health facility. Senate confirmation of Doctor Klopp's nomination is required.

THE MICHIGAN DOCTORS Political Action Committee has a major membership drive underway at this crucial time in the nation's political scene. Physicians may contribute to and join MDPAC when they remit their 1980 MSMS dues. Sustaining memberships are $150. Further information is available from Gary Anderson at MSMS headquarters.

MSMS HELD A NEWS CONFERENCE Dec. 18 to announce 10 more Michigan jails joining the Michigan Jails Project aimed at improving health care for inmates. Three TV stations, both wire services, six radio stations plus two other newspaper services attended or carried the story to media throughout the state. Taking part were MSMS President Ernest P. Griffin Jr., MD, and Austin A. Aardema, MD, chairman of the Michigan Jails Project.

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MSMS Council highlights

At its Dec. 12 meeting, the MSMS Council:

1) Formally requested physicians involved with Health Systems Agencies to report to the Council through the MSMS/HSA Physician Support Center about local bed reduction plans and the impact those plans will have on medical practice in their home areas. The support center staff is to make a report and specific recommendations to the Council Jan. 23.

2) Okayed a statement of principles and recommendations to guide physicians who are called upon to participate in peer review, disciplinary and other activities relating to the reasonableness of health care costs or standards. The principles express MSMS concern with and commitment to the proper distribution and delivery of medical care. The recommendations spell out the process for investigation of complaints against a physician or other provider. (Full details will follow in Michigan Medicine.)

3) Empowered the MSMS Physician/HSA Support Center to provide administrative services, including the holding of funds, for physician health planning groups, such as advisory committees to HSAs around the state.

4) Established a financial assistance plan for impaired and disadvantaged physicians. The plan will provide a revolving fund for interim loans or occasional bequests to physicians who are destitute or impaired and in dire financial straits. Funds are to come from a $1 per year dues allocation by each member as needed.

5) Referred action on emergency medical services categorization back to the Steering Committee on Health Planning for further study in light of the AMA House of Delegates' actions at its interim meeting early in December.

6) Called on the MSMS Board of Managers to evaluate or prepare plans and programs for capital expansion or improvements when expenditures from the reserve funds are required.

THE MSMS/PHYSICIAN SERVICE GROUP INC., the new for-profit member services subsidiary of the state medical society, has been boosted by Medical Economics. The national magazine suggested the MSMS/PSG route as a way to go in states where physicians are unhappy with the quality and availability of practice management services. Medical Economics noted that the MSMS/PSG charges less for its services than the average charged per hour by private management consultants.

COMPLETE DETAILS and a registration form for the 1980 Michigan Conference on Maternal and Perinatal Health will appear in the January issue of Michigan Medicine. The conference is scheduled March 5-6 at the Hyatt Regency Dearborn. Information is available from Katie Brewbaker at MSMS headquarters.

THE MICHIGAN STATE SENATE has a new toll-free action line physicians might want to keep handy. It is 1-800-292-5893, and will get the caller in touch with his or her own senator. Promotional literature promises your message will be relayed to your senator's office the same day you call, and your senator's office will call you back.

MSMS studying HSAs' plans for hospital bed reduction

As this issue went to press, six of the eight healt systems agencies in Michigan were preparing to subm their plans for bed reduction by the Dec. 21 deadli The plans go to the Statewide Health Coordinating Council, which will have its first official meeting to consider the six plans on Jan. 17.

MSMS is concerned with the hospital bed reduction issue which is absorbing more and more physicians' time and energies. The MSMS Council recognizes tha each of the six areas may have varying reactions to the regional plans. However, it is asking local ph sicians how MSMS may help achieve the desired local objectives.

As an aid to Michigan physicians, Michigan Medicine January "Health Planning Update" column will be dev ed to an historical view of the debedding issue, an several pages of the February issue will go into debedding in depth.

MDs may not practice if licenses laps

Physicians are not permitted to practice if their licenses lapse until their licenses are renewed. This reminder comes from the Michigan Board of Medicine and is meant for those MDs who are delinquent in certifying they have met CME requirements and in renewi their licenses. In accordance with the Public Healt Code, says the Board, the MD's license lapses the da after the expiration date printed on the current renewal license. Second notices will be sent to those physicians whose licenses have lapsed, and failure t heed that second notice within 60 days will lead to revocation of the license. Further, the doctor's na address and the date the license lapses will be forwarded to the Department of Public Health, the insur commissioner and state and federal agencies which administer health care programs.

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